The Canadian Nurse

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NEW PRODUCTS 540
OPEN A BETTER WAY ..... *H. G. McArthur* 543
CANCER OF THE BREAST ..... *G. A. Lane, M.D.* 547
NURSING CARE IN MASTECTOMY ..... *M. Stewart* 549
THE REHABILITATION OF MARY JONES ..... *C. Leleu* 551
ALLERGY AND ANAPHYLAXIS ..... *C. H. A. Walton, M.D.* 553
CARING FOR THE CARDIAC PATIENT ..... *A. Pumphrey and M. Allen* 557
WE SERVE IN THE FIELD OF PERSONNEL ..... *M. Kerr* 562
DYSTONIA MUSCULORUM DEFORMANS ..... *A. Gerrish* 563
THE OUT-PATIENT DEPARTMENT ..... *R. K. Ackhurst* 567
THE NURSING TEAM IN THE HOSPITAL ..... *M. G. Russell* 572
L'ENFANT AU COEUR MALADE ..... *C. Talbot* 574
TRENDS IN NURSING 577
ORIENTATION ET TENDANCES EN NURSING 579
C.N.A. RESOLUTIONS 581
INTESTINAL OBSTRUCTION ..... *B. Tomander* 583
BOOK REVIEWS 587
NEWS NOTES 591
OFFICIAL DIRECTORY 608

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Between Ourselves

It is ten years since a president of the Canadian Nurses' Association has succeeded herself in office as **Helen G. McArthur** has done this year. Thinking about this, we began to look back through accumulated files to find how often this practice had been followed. We found, for example, that "Three Centuries of Canadian Nursing" does not contain a list of the ***past presidents of our association.*** No list of them, to our knowledge, has been published within recent years in *The Canadian Nurse*. Perhaps the following list will be of greatest value to history of nursing classes but it will also serve to recall the names of those staunch women who played a vital part in the building of our association. The names of those who have passed away are indicated by italics:

1909-12.....*Mary Agnes Snively*
1912-14.....Mary Ard Mackenzie
1914-17.....*Sharley (Wright) Brown*
1917-20.....*Jean Gunn*
1920-22.....Edith McPherson Dickson
1922-26.....Jean (Browne) Thompson
1926-27.....*Flora Madeline Shaw*
1927-28.....Mabel F. Gray
1928-30.....*Mabel F. Hersey*
1930-34.....Florence H. M. Emory
1934-38.....Ruby M. Simpson
1938-42.....Grace M. Fairley
1942-44.....Marion Lindeburgh
1944-46.....Fanny Munroe
1946-48.....Rae Chittick
1948-50.....Ethel M. Cryderman
1950- .....Helen G. McArthur

Miss McArthur's ***presidential address*** to the recent convention forms our lead article this month. Her comment regarding the backward glance along the road we have come in nursing reminds us of another's comments on a similar occasion. That speaker contrasted the broad forward view from the front seat of a car with the somewhat limited glimpse of the road that had been covered that may be seen through the rear-vision mirror. The latter serves a very useful purpose when any change of direction is contemplated to be sure the road is clear for such a change. Let us keep looking ahead with Miss McArthur.

* * *

As **Dr. G. Allan Lane** *points out in his discussion of* ***cancer of the breast,*** this is a disease of middle and later life, though it sometimes occurs in the young. Statistics reveal that, next to the uterus, the breast is the commonest site of cancer in women. At the same time, we must not lose sight of the fact that the formation of cystic tumors in either one or both breasts is a fairly common occurrence at about the time of the menopause though they may occur earlier. The important point to emphasize in all cases of lumps in the breast is that they should be excised and examined microscopically to rule out the possibility of malignancy.

Mary Stewart outlines the general principles of nursing care before and after a ***mastectomy.*** Because of the extensive area of the operation and the loss of blood, these patients are especially subject to shock. Special care is essential. **Constance Leleu** shows dramatically the help that the ***visiting nurse*** can give the patient after she has returned home.

* * *

With this issue we commence an exceedingly interesting and informative series of articles on the many aspects of ***allergy.*** When we wrote to **Dr. C. H. A. Walton** of Winnipeg for an article on this fascinating topic, he very kindly suggested that we seek permission to reprint the series of five addresses that he had delivered at the Annual Summer School of the Vancouver Medical Association last year. He authorized us to make such deletions as we considered necessary in order that the articles might suit our requirements. Dr. J. H. MacDermot, the editor of *The Bulletin*, graciously added his permission. We know that this series will bring you much new and different information. Don't miss one issue for the next few months.

Convention Copies Still Available!

National Office has numerous copies of the ***Convention (May) Issue*** of the Journal available for those who wish to have them—at 35 cents each. Write to: **The Canadian Nurses' Association, 1411 Crescent St., Montreal 25, Quebec.**

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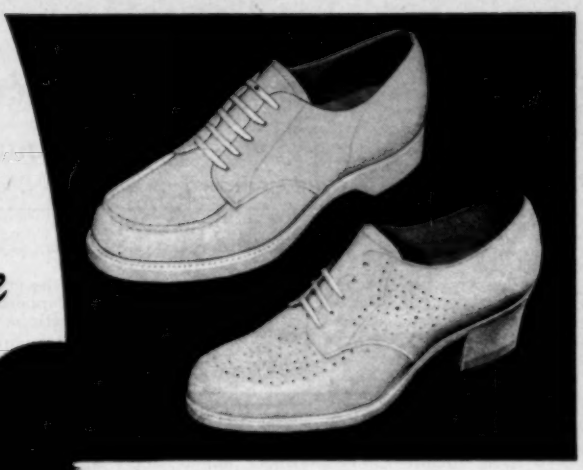

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BEMOTINIC Liquid

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Administration—One teaspoonful 3 times daily for children and twice this amount for adults.

TRYPTAR

Manufacturer—Armour Laboratories. Canadian Distributor: Laurentian Agencies Ltd., Montreal.

Description—Highly purified crystalline Trypsin in 30 cc. with diluent vials containing 250,000 Armour Units (250 mg.). One unit is the amount which upon incubation at 25° C. for 10 minutes will cause a specific degree of decomposition of a suitable preparation of hemoglobin.

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Usual dose (attacking): 8 to 12 tablets per 24 hours to be taken in 4 to 6 doses during the day as required, for 15 days.

Exceptionally strong doses (intensive treatment of flutter): 16 to 24 tablets per day at the rate of 2 tablets every 2 or 3 hours or, if preferred, 1 tablet every hour.

Note: In principle, not more than 2 tablets should be taken at a time. Fractionation of dose is indispensable for obtaining maximum results and to avoid intolerance (nausea and vomiting) which, if encountered, ceases with temporary cessation of treatment.

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The
CANADIAN NURSE

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Open a Better Way

Presidential Address

THE THEME of our meetings, "For Better Service—Today and Tomorrow," "Pour Mieux Servir—Aujourd'hui et Demain," adequately expresses our reason for our being here. If we are to improve our service we must periodically make an appraisal of our activities—both our achievements and our failures. The Canadian Nurses' Association can meet its objectives only if we leave this meeting with our eyes turned forward. We must not walk backwards into the future, looking still at the way things were done in the past.

This is not to suggest that we should cut ourselves off from past history. It is a duty to learn all we can from the experience of those who have gone before us. But such knowledge should be as stepping stones to progress, not millstones to drag us back. As Sidney Smith so aptly remarked, "We must avoid confusing the wisdom of our ancestors with the folly of their descendants."

It seems to me that in recent years nurses have been developing an all too critical attitude towards themselves and those around them. Our problems seem so great to us that we feel that no improvement is possible. We forget our potentialities. We have even been known to turn aside the outstretched helping hand of non-nurses.

Ballard-Jarrett, Toronto

Therefore, although the purpose of this biennial is to find better ways to provide adequate nursing service for the people of Canada, I, as president, intend to grasp this opportunity to set the background by reminding you of our past history and of our achievements and failures.

Let us go back 20 years. At that time the Canadian Nurses' Association had 8,000 members. The late Dr. G. M. Weir had just completed an 18-month study of the nursing situation in Canada. This survey was sponsored jointly by the Canadian Nurses' Association and the Canadian Medical Association. The cost was borne by the two associations—70 per cent by the nurses, 30 per cent by the doctors. The survey was received with great enthusiasm for there were many recommendations to show a better way. An article in *The Canadian Nurse*, following the publication of the Weir Report, discussed "The Survey in Terms of Action," with an introduction as follows:

> Canadian nurses are fortunate in having, at this period of crisis, a chart whereby national and provincial nursing policy may be guided. That chart is the Survey in which may be found a searching diagnosis of our ills and also many valuable suggestions for the cure and prevention of those ills.
>
> Diagnosis may sometimes be so long delayed that the patient succumbs before anything can be done for him. Happily, this is not the case in Canada. The Survey is in our hands, it has already been closely studied by our national nursing leaders, and we have now arrived at a stage in which each province is ready to critically examine it in relation to a possible solution of its local problems. In other words, the time for action has arrived.

Did we take action? Are the recommendations all fulfilled or adapted to the rapid scientific and social changes which have taken place in the amazing 20 years just gone by?

I was a student nurse in 1932 and a university student in 1933 and I remember well the diligence with which my nose was applied to that grey book. I also remember that I received a better mark than one of my classmates on a paper prepared on the report because I set the recommendations out in red ink while she used only blue. But, since that time, how often have I returned to that report for guidance? How many times have you? How many of us have ever read the report at all?

It would be impossible in the time at my disposal to reiterate the many recommendations that have not been implemented as well as those which have been only partially realized. Perhaps the report set out more than the nurses and the citizens of Canada could possibly have accomplished in this 20 years, even if we were all sincerely trying to *make* the future of nursing in Canada live up to all its possibilities. The 1932 Survey states:

> The real leaders in the nursing profession, which is now passing through a somewhat feverish stage of transition, have set before themselves high ideals of accomplishment and service. Their program, however, is neither that of the mere visionary nor of the fanatic. These women of foresight and action, whose cause is capably supported by not a few members of sister professions and of the laity, have envisaged the potential greatness of their profession as an agency for the promotion of human betterment and the relief of physical and mental distress. Theirs is a venture of faith—but of faith that removes mountains of opposition—and there are not a few of such mountains to be removed!

What have we to report 20 years later? Again, I cannot outline for you all the achievements but let us, for a few minutes, praise ourselves and those who have assisted us. You are only too well aware of the phenomenal expansion of health services during this period. This has contributed much to the achievement of our aims while at the same time adding to the complexity of our problems. A review of the Nurse Registration Acts of the present as compared with the past convinces us that the standards for both education and practice have been raised significantly. The remarkable progress in the establish-

ment and growth of education for nurses within the university, and the provision of financial aid for those wishing to undertake such courses, are further indications of advancement. The auxiliary worker has been brought into the picture. There is much evidence of a fuller realization of the demand for well-equipped workers at various levels. There is increased financial support, as for example the health grants offered by the Department of National Health and Welfare in cooperation with the provincial Departments of Health.

The nurses of Canada are no longer isolated in their search for solutions to nursing problems. Nurses the world over are facing similar situations and it is becoming increasingly possible to share experiences and successes.

The International Council of Nurses is now closely associated with the Florence Nightingale International Foundation and has an official relationship with the World Health Organization. This development creates new opportunities for the exchange of thought within the profession. Equally important, it provides a means through which the participating governments can assist nurses to provide better services for the people of the world.

In this 20 years the membership of the Canadian Nurses' Association has grown from 8,000 to over 30,000. There are nearly 7,000 more students in our schools. Of course, it is still not enough. There is an estimated shortage of over 8,000 nurses to meet the demands of the institutions and agencies providing nursing service. We know that there is an acute need for more well-qualified instructors. We know that student withdrawals from our schools of nursing are still too numerous. Failure in classwork and health reasons account for nearly half of the withdrawals and indicate areas for further study. However, the total withdrawal rate in Canada, 19.4 per cent, compares very favorably with that of Great Britain, 50 per cent, and that of the United States, 30 per cent.

We know, then, that we have been going ahead. We are happy to see indications that Canadians have recently been talking less about the shortage of nurses and more about the increased demand that has created new problems needing new and different approaches.

The annual reports from the provincial nurses' associations indicate exciting and realistic attacks on some of these problems, such as studies to increase the supply of nurses and to improve the quality of service. Institutes and refresher courses have been given in abundance with greater use of university resources and closer coordination with Departments of Education. Itinerant educational programs have been tried. Bursaries are available for those who wish to take advanced preparation. There is continued and extensive work on curriculum construction. Faculties in schools of nursing have been added to and facilities improved. Financial assistance for the building of nurses' residences has recently become available. Much of this is made possible by the increasing health grants which the nurses have been quick to accept and use for the improvement of themselves and the service they render.

Personnel policies have been studied and recommendations are now welcomed more readily by employers than in the past for it is becoming clear to all that both have a common purpose—the stabilization of nursing service.

There has been steady growth in the programs of the provincial nurses' associations with many indications that their services are finding a sound and more uniform place in the community. You will join with me, I am sure, in congratulating the Registered Nurses' Association of Ontario on their success in obtaining their new Act after years of seeking the rights that had been granted to the nurses of other parts of Canada. The Registered Nurses' Association of Ontario is now the registering body and has the authority to set standards for nurse registration in Ontario.

So much for the past 20 years.

Again we have boldly sought the opinion of people from fields outside our own profession. We knew that we had not attained all that was planned for us in 1932 but we were also aware we could not solve our problems alone or look at ourselves objectively. During the next four days we are to hear the results of the findings of the studies which have been made this year. They may make us feel proud but uncomfortable. They cannot help but expose our weaknesses. We asked them to do so. Many of them we may have already recognized but we have, on occasion, closed our eyes in the hope that they would disappear of their own accord. But there they will be in black and white and now, having sought advice, we must keep open minds. We must be ready to accept new approaches and new methods with enthusiasm and a will to make them work.

Nurses alone, of course, cannot put all the recommendations which will be presented into action. But now, perhaps more than ever before, there are indications that others are willing to help. The recently appointed Canadian Commission on Nursing, composed of representatives from the Canadian Hospital Council, Canadian Medical Association, and Canadian Nurses' Association, is presently serving as a working party to study ways and means of improving the nursing situation. Their stated purpose is to recommend measures to ensure the provision of adequate nursing services for Canada's health needs. This group will make good use of the facts and recommendations to be presented by Dr. Lord, Dr. Jewett, Mr. Josie, Mr. Walker, and our own members during this biennial meeting.

There is ample evidence on every hand of the increasing interest of the public in nursing service and its distribution and in nursing education. This interest can be translated into action once the methods of improving the nursing situation are known and understood. Nurses must study and inform themselves for future tasks but no longer need they feel that they must do the whole job alone.

So, during this week, we will draft our plans for the future. What we are going to do is of much more importance than what we have left undone. Our past has no other mission than to equip us for the present and the future. I can assure you that the program of this biennial meeting will provide you with much sound equipment. The presidential address of 1972, perhaps given by some student nurse present today, will report on the soundness of our planning. The destiny of the nursing profession in Canada is in your hands. "Into the future open a better way."—Florence Nightingale.

HELEN G. MCARTHUR
President
Canadian Nurses' Association

Nursing Sisters' Association

The May meeting of the *Edmonton Unit* was held at the home of Mrs. Hunter. At this time E. Robinson, unit historian for 25 years, was presented with a cheque as a gesture of appreciation for her work in compiling a scrapbook of historical materials collected by the unit. The presentation was made by Mrs. J. O. Baker. Letters from ex-members, along with one from the All Canada Association, were read in connection with this unique achievement. (See *May issue, p. 351*).

The annual meeting of the *Hamilton Unit* was held in February when a buffet supper was served. The 1951 executive were re-elected for another year and music and cards were enjoyed. Several new members were welcomed at the May meeting when discussion ensued regarding a Remembrance Day Tea to be held in November. The September meeting will take the form of a picnic.

At the February meeting of the *London Unit* the guest speaker was Ethel Lane who told the members of her trip to Ceylon. Formerly night matron at Westminster Hospital, she has now taken up residence in Colombo as the wife of Dr. D. E. Wijewardene. A very successful bridge was held by the unit at W.H., proceeds going towards patriotic projects. Monthly meetings have been discontinued, the members to meet quarterly in future.

Cancer of the Breast

G. Allan Lane, M.D., F.R.C.C.

The female breast has the unenviable distinction of being one of the commonest sites in which cancer arises. This disease ranks high among the causes of death in women, particularly in the age group from 40 to 60. That this is so is rather disturbing. Surely in such a prominent and accessible organ one should expect to discover and treat the disease at a more favorable time than is possible elsewhere. Yet this is not so and, all too often, the reason is either ignorance or carelessness. It is so disheartening to hear a patient say of a lump that has been present for one or more years—"But, doctor, it never hurt me once," or very occasionally to have one say of a similar lump—"I saw a doctor a year ago but he said it wasn't important."

It is apparent that ever-increasing education and vigilance are necessary if this problem is to be overcome. As yet we know too little of the causes of cancer of the breast. Some facts are known, however. It is rare before 35. It is commonest at the menopause. It is slightly more common in women who have not borne children. Contrary to the usual lay opinion, it is rarely, if ever, caused by a direct blow on the breast.

As far as signs of the disease are concerned, there are two main points that we have to disseminate to the public. These are, first, that the appearance of any lump in the breast is of importance and, second, cancer of the breast is usually painless except in the late stages. Occasionally the first evidence of cancer of the breast is the appearance of a bloody discharge from the nipple or, rarely, the presence of a secondary growth elsewhere in the body. Most commonly, however, a lump is discovered in the breast by accident.

Dr. Lane is a practising surgeon in Hamilton, Ont.

Here, then, is one of the answers to the problems this disease presents. Any woman past 30 should be taught to examine her own breasts for the presence of lumps or else to report at regular intervals to her family doctor for this purpose. From the foregoing, one must not jump to the conclusion that all lumps in the breast are cancerous. This is certainly not so. Many, indeed most, lumps in the breast are harmless. However, it is sometimes exceedingly difficult to distinguish the dangerous from the harmless. Often excellent clinicians stumble if they try to draw too close a distinction between the two groups. This is the reason why we remove any lump in the breast about which there is the slightest doubt. Usually such lumps are harmless but our vigilance is well rewarded when an unsuspected cancer is brought to light by this means.

Generally speaking, benign lumps are small, soft, smooth and move about freely under the skin. They may vary in size from time to time, particularly with the menstrual periods, and do not grow rapidly. On the other hand, cancers are hard, irregular, variable in size and tend to become fixed to the tissues. Even a cancer may remain very small for many, many months but usually there is a relentless increase in size. From the clinical point of view, one can often state definitely that a particular tumor is a cancer but one cannot afford to be too didactic about deciding that certain growths are harmless.

In summary, the finding of a lump in the breast is the responsibility of the patient or of the family doctor when making a routine examination. The responsibility of what to do about it is the family doctor's and, if necessary, the surgeon's.

Supposing we have a patient with a lump in her breast. What should

be done for her? Unless one is 100 per cent sure that the lump is benign, it must be removed and the diagnosis made conclusively by the pathologist. This is best done by admitting the patient to hospital, removing the lump under general anesthesia, and examining it carefully both in the gross and microscopically, being quite prepared to continue with a radical removal of the breast if necessary.

Once a cancer of the breast is diagnosed, what is the treatment? This is simply stated. The treatment of cancer of the breast is surgical removal of the breast and axillary contents as cleanly and as thoroughly as it is possible to do so. Has the x-ray then no place in the treatment of cancer of the breast? Indeed it has! It is the most valuable adjunct to surgery that we have. It can cure many cases of cancer of the breast and can render many more amenable to surgery. Many times it controls or cures small pieces of cancer left behind by the surgeon. Notwithstanding this, the primary treatment of cancer of the breast is surgical.

Despite such positive statements, the treatment of cancer of the breast is really not quite that simple. One reason is that cancer of the breast is really not one disease but several. It is not found at one stage of growth only but at many stages. Thus we find cancer divided into scirrhous or hard and medullary or soft types. Even these divisions are broken down by the pathologist into various grades from one to four, depending on the microscopic appearance and his estimate of their rate of growth.

The surgeon, on the other hand, divides the disease into four stages, depending on the extent of the growth when first seen. Stage 1 means a breast tumor that is early and entirely confined locally, whereas stage 4 means a hopeless growth from the point of view of cure. Depending on the type and stage, decision is made as to whether to treat the case by surgery, x-ray or both. The operation of choice, as mentioned, is radical mastectomy. This is a severe, time-consuming job but fortunately the operative mortality is low. The whole breast, underlying muscles, and the axillary contents are removed completely, leaving only those structures passing through the axilla that supply the arm. As a result there is a very extensive exposure with some tendency to shock and there is usually sufficient blood loss to warrant blood transfusion during or after the operation. Because of the wide exposure, there is often oozing of blood post-operatively. Sometimes this is considerable. Consequently these wounds are always drained and a firm pressure dressing applied before the patient leaves the operating room. In the immediate post-operative period, one needs only to be sure of the patient's general condition and check the dressings to see that bleeding is not excessive. A routine hemoglobin test the next day is an excellent check to be sure that blood replacement is adequate. There is moderate pain for a few days but this is easily controlled by sedation.

Once the immediate post-operative period is passed, free movement of the patient is encouraged. Dressings are changed daily. The drains are shortened regularly. The sutures are removed about the 9th or 10th day. The patient is allowed up as soon as her general condition and comfort allow.

It is most important, from the second day on, to supervise the movement of the shoulder joint on the side of operation. If this is not done, the stiffness that is a natural consequence of such bold, surgical encroachment will be very disabling. Abduction, in particular, is slow to return. The patient must increase her range of movement each day so that, by the time she leaves hospital, she should be able to comb her hair properly, using both hands. Sometimes there is swelling of the arm of varying degree. This is controlled by elevation, massage, and pressure bandages. Occasionally this is a permanent and disabling feature of the treatment. However, it is a small price to pay for the cure of the patient.

Quite often, due to the amount of

tissue which needs to be removed, there is sloughing along the skin margins from tension. Moist compresses, usually of the hygeol type, hasten separation of any dead tissue. If this sloughing is extensive, skin grafting may be necessary. Usually, however, the wound granulates in itself very rapidly. Other post-operative complications are uncommon. As in any surgical procedure, infection may occur. Thrombosis and embolism are possible but are rare. Delayed hemorrhage is also very uncommon. Usually the patient is ready for discharge by the 10th or 14th day and at this time, in the uncomplicated case, the wound is completely healed and needs no further attention. If the scar is tight, it may be massaged gently with olive oil or lanolin. Shoulder exercises may be required for a further two or three weeks.

For the patient's own welfare and also to improve the treatment of this disease, each case must be followed carefully. Frequent visits to the follow-up clinic enable us to determine the efficacy of our therapy and often to pick up a recurrence early enough to eradicate it completely.

The above discussion outlines the way an early and favorable case of this disease is handled. What then of the others who come in too late for cure? Are they merely abandoned? No. Even in an advanced case, the judicious use of surgery, x-ray, the various sex hormones, and other means at our disposal can offer a great measure of relief and comfort to an otherwise hopeless individual.

This then is a quick look at the problem of cancer of the breast from a surgeon's point of view. While in an advanced case the outlook is gloomy, in early cases the future is bright. Surely in this disease we can do much to bring patients in for treatment while there is yet time. The number of such cases that we now see and the results that we now obtain are more than enough reward for the eternal vigilance and constant care that is necessary in the supervision of patients with this dread disease.

Nursing Care in Mastectomy

MARY STEWART

THE WOMAN who enters the hospital for removal of a tumor of the breast is aware of the possibility that it is cancer. Usually this woman is dominated by fear. Common practice is to do a biopsy with the patient prepared for a more extensive operation in case the microscopic examination shows the presence of cancer. Fortunately, many will prove to be innocent tumors. This group needs little nursing care—the relief of their fear is sufficient.

The women we are primarily interested in are those who are not so fortunate. The patient's history is usually an accidental discovery of the lump in the breast while bathing or dressing. Such a lump almost always is painless. Pain is not a common symptom of breast cancer and certainly not an early one. As well as the fear that the tumor may be malignant most women dislike the idea of having a breast removed. At this time a patient needs all the sympathetic understanding a nurse may be able to provide.

On the afternoon of the patient's admission to hospital the operative area is prepared from midline to midline as well as the axilla and upper arm on the side of the breast involved. A good fluid intake pre-operatively is

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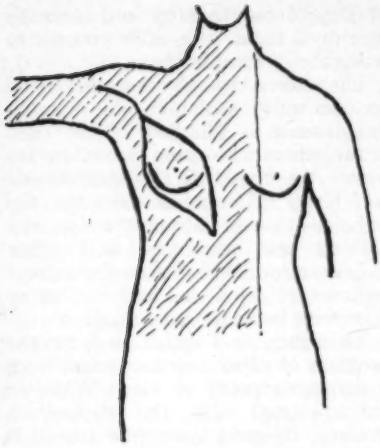

Area prepared for radical mastectomy—all the way around the arm and from the midline at the front to the midline on the back. Frequent incision line shown.

essential to aid fluid balance post-operatively. Before bedtime a cleansing enema is usually given. Generally the anesthetist leaves an order for a sedative to ensure a good night's rest for the patient. It is necessary to have the patient's blood typed and at least 1,000 cc. of blood available before the operation. Mental preparation pre-operatively is a requisite. The nurse should refrain from mentioning the possibility of cancer to the patient but rather stress the number of cases in which simple tumors are found.

The immediate post-operative care is common to all patients having had major surgery: prevention of shock, sedation to alleviate pain, relief of nausea and vomiting, comfort and safety. A blood transfusion is usually given during the operation and may be repeated on return to the ward. Intravenous fluids are not usually ordered unless indicated for nausea. A pressure dressing is applied in the operating room to prevent fluid from collecting in the tissues. Very frequently now, this is a sealed Elastoplast dressing which is changed by the surgeon in four or five days. However, there are still a few patients who return to the ward with an open dressing, secured firmly with a binder.

During the first 12-48 hours, post-operatively, this patient requires considerable assistance and encouragement. She must be turned frequently and the arm and shoulder on the affected side should be adequately supported. The tendency is to breathe shallowly to avoid pain. Therefore deep breathing must be emphasized. Fluids by mouth are given as soon as possible and the diet is increased rapidly, as tolerated.

In the case of an open dressing, a good deal of responsibility lies with the dressing nurse. It is most important that she observe the incision closely for signs of breaking down, gaping, or the formation of fluid pockets.

Most surgeons advise early movement of the arm and shoulder joint. The nurse would be wise to begin mild exercises on the first post-operative day and then gradually increase them. Urging the patient to comb her hair is an objective which stimulates interest. However, exercises are definitely contraindicated if skin grafting has been employed. The majority of patients are allowed up early in the post-operative period.

The patient's mental attitude governs her recovery to a considerable degree. Depression results from the knowledge that this mutilating operation is done for cancer. This depression can be overcome and a brighter outlook developed by open discussion with the nurse. The younger the patient the harder it is for her to be reconciled to her altered appearance.

The use of prosthetics may be introduced and the means through which they can be obtained is discussed.

While the patient is still in hospital her x-ray treatments are started. The number of treatments will vary according to the stages referred to in Dr. Lane's article. After returning to the ward, the patient may complain of nausea or vomiting. Frequently, too, she may feel depressed and fatigued. These symptoms may be

counteracted by rest and prescribed drugs.

When the time comes for discharge, our patient should be ready to resume her normal activities and to lead a full and happy life!

The Rehabilitation of Mary Jones

CONSTANCE LELEU

"GOOD MORNING! Did someone send for a nurse?" The door opened a little wider and the questioner was ushered into the clean but modest little home by a sad-faced middle-aged woman. "It's my daughter, Mary, Nurse. She's had her breast off, and, oh Nurse, it's cancer!" The last despairing whisper ended in a deep sob. "Oh, come now, Mrs. Jones, it may not be as bad as you think. How long did your daughter notice the trouble before her operation?" "She did not notice it at all, Nurse. It was the doctor at the place she works. You know how they examine the girls every year. Well, when Mary's turn came, the doctor found this lump in her breast and said she would have to go to the hospital. I wanted her to wait awhile but the doctor said she must go right away. That was three weeks ago and, when he told me it was cancer, I just couldn't believe it." With this, Mrs. Jones broke down completely. "Mrs. Jones, did you ever hear cancer is curable? The fact that Mary was treated so soon makes it quite possible that she will be all right. Now let us think how we can help her. The doctor says your daughter will need her dressing changed daily for a week or so. Will you get me a pan to boil these instruments?" The next few moments Mrs. Jones forgot her worries assembling towels, newspapers, a china eggcup put on to boil with the instruments, and then led the way to Mary's room.

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"Here's the nurse the doctor sent, Mary." Miss Brown entered the room to see a pale young woman in her early thirties, wearing a faded housecoat, hair in disarray, supporting her right arm close to her body. Fear and resentment burned from her dark brown eyes as she lay dejectedly on top of an unmade bed. "The parcel from the drugstore is on the dresser. The doctor ordered it," she remarked.

After placing her bag on the newspaper Mrs. Jones had spread on one end of the dresser, Miss Brown opened the parcel and removed Nivea Creme, hydrogen peroxide, adhesive tape, and a small quantity of gauze and absorbent cotton. "I hope you have got everything you need, Miss Brown, as I can't afford to keep putting money out with nothing coming in," and with this Mary's mother went out and closed the door.

While attempting to engage Mary in conversation, the nurse protected the bedside table with newspaper and made a paper bag for the soiled dressing. She had placed the drugstore articles conveniently as Mrs. Jones appeared with the sterilized instruments which were also placed on the table. Miss Brown poured some peroxide into the eggcup, opened the gauze and absorbent, then turned towards Mary. "I'll help you take off your gown, Miss Jones" she said. While doing this, she noted how stiffly the right arm was supported. With difficulty the area to be dressed was exposed and draped with towels. "You can undo the tapes while I am washing my hands," she called back, vanishing into the bathroom. Mary, who had not attempted to do one

thing for herself for three weeks, was surprised into loosening the knots.

The dressing removed, Miss Brown noted the reddened area, extending up the shoulder. (Therapy reaction, she surmised). Noting Mary's turned head she inquired, "How long have you had this?" Involuntarily, Mary glanced down, "I don't know, I never looked before." "Well, it's not so bad, is it? See that nice clean incision. That little hole will soon heal, once the drainage stops." For the first time, Mary showed interest, as she watched the deftly moving forceps swiftly cleanse around the incision and apply fresh gauze. "A little Nivea Creme on that shoulder should help. That's what the clinic doctor orders," and Nurse Brown suited her action to the words.

"I think a binder will help keep this pad in place and make you feel more secure. This towel will do. How about some wide ribbon for shoulder straps? My! I'm glad you had these safety pins. I usually have trouble when there are no babies. Now into the bathroom and you can wash, while I clear up here and straighten up the bed." In amazement, Mary found herself seated at the washbasin, with instruction to sponge-bath herself—something she had almost forgotten how to do and cared less.

Down in the kitchen, putting her instruments on to boil, Miss Brown queried Mrs. Jones. "Has Mary a button-front dress?" "Yes, Nurse, but she always says—Why bother getting dressed?" "Will you go and get it and lay out the rest of her clothes? I will manage the rest"—(I hope, she thought to herself).

Gathering up the clothes, Miss Brown went into the bathroom. "I'll wash your back, and then we will get you dressed." Ten minutes later a different Mary was sitting by the window, having her hair combed. "What kind of work do you do, Miss Jones?" she was asked. "You mean, what I *used* to do. I'll never be able to type with this," lifting the stiff arm, "and when my friends see me they will know I've had my breast off, and I know I have cancer and am going to die!" It finally was out. Miss Brown waited a moment, putting the last bobby pin in place, then came and sat down in front of Mary.

"Miss Jones, listen! You're not going to die. You work with figures and you know their meaning. Doctors have proved 75 to 80 per cent of young women like you are alive and well five years after their operation and likely to live many more useful years. Why I had a patient yesterday who had her breast removed 25 years ago and has not had a bit of trouble. As for your friends, we can get you a prosthesis—that is a breast-form made of foam rubber—which even your best friend will not recognize even if you want to be a sweater girl. The stiffness, and perhaps swelling will take time, but using that arm as much as possible, and working the fingers should help. Tomorrow I will show you some exercises especially designed to strengthen the arm muscles. Don't worry about the dressings. The Cancer Society have a dressing supply station called 'The Little Red Door' and they will let you have, free of charge, all you need. All you have to do is wrap and sterilize them in the oven and I will show you that, too, when they come."

Gradually the fear and resentment was replaced by a glimmer of hope and Mary managed a weak smile, as Miss Brown took her bag and went down to the kitchen to collect her instruments. As she put on her hat and coat, she left final instructions with Mrs. Jones. "Let Mary do as much as possible for herself—it's really better for her. And about her meals—encourage her to come to the table. I know you will give her nourishing foods and I will bring you some new recipes, dishes made with foods rich in iron. Don't worry—everything is going to be all right."

The next morning Mary was ready for Miss Brown, even to having the newspapers placed and towels ready. The dressing done—"Now for the promised exercises. Stand facing the wall and place your hands, with palms flat against it. Now raise them, using the wall for support as far as you can.

It will help the stiff arm—ever heard of climbing the wall? This is it. Each day you must try and get your hand up a little higher. Tomorrow I will teach you another exercise so practise this one all day."

A few days later Mrs. Jones was advised to let Mary use the vacuum cleaner, using the right arm, of course. Putting away dishes involved pulling open drawers and doors These simple duties not only served in the rehabilitation of the arm muscles but gave Mary the feeling of usefulness. A new blouse, purposely opening down the back, was a stickler for a few days; so was putting up her hair in pin curls; but Miss Brown knew these were helpful and disguised methods of occupational therapy and spurred Mary on until she mastered them.

When the incision was healed, Mary, with the nurse's help, got into a warm tub bath, which proved a great comfort, especially when the affected side was submerged. Another great step was taken when Mary went alone for her last x-ray treatment. The doctor told her she could start back to work any time, as long as she reported periodically for a check-up.

As Mary walked out the hospital door, a trim, self-confident young woman, she waved good-bye, with her right arm, too, to her therapist friend. "There goes one trophy of man's fight against cancer," he remarked.

Allergy and Anaphylaxis

General Principles

C. H. A. WALTON, M.Sc., M.D., F.A.C.P.

DISEASES, NOW KNOWN to be manifestations of allergy or altered reactivity, have undoubtedly existed throughout human history but their nature and their relation to each other have been understood only in the past 40 years. The diseases themselves are old and have been known for centuries. The allergic concept is a little more than a generation old.

Asthma is referred to in the writings of Hippocrates but he did not distinguish it clearly from other forms of dyspnea. In the fourth century Aretaeus, in the time of Galen, gave the first clear description of the asthmatic paroxysm but it was not until the late 17th century that Thomas Willis and Sir John Floyer clearly distinguished bronchial asthma as a clinical entity. Characteristically, bronchial asthma is a periodic form of difficult breathing, often with completely free intervals and with no clinical or pathological evidence of heart disease or of inflammatory or neoplastic disease of the lung. It is, in fact, periodic bronchial obstruction.

Asthma has been recognized clinically for centuries but its cause and its pathology were not understood. In this connection, it is interesting to note the story of one Jerome Cardan, a noted clinician of Padua, who was called to Edinburgh in 1575 to treat a bishop who was suffering severely from asthma. Cardan wrought a miraculous cure by advising the elimination of the bishop's feather bed. There is no doubt that this old clinician, who was inevitably a good observer, had noted before that there was a relation between feathers and asthma. In his extensive practice he had probably observed this relationship many times but he formed no theories or conclusions about it. He simply applied it empirically and obtained good results in some cases.

Laennec thought that the typical asthmatic paroxysm was a neurosis, using the word neurosis in the sense

of a functional condition and not in the sense of nervousness that is often implied today. Laennec's idea that it was a reversible functional disturbance of the bronchi was remarkably close to the truth but the implication that the disturbance is mediated by the nervous system was unfortunate and probably delayed progress. As long ago as 1819, Bostock, in England, described a clinical syndrome, suffered by himself and a few of his patients, which was characterized by severe nasal catarrh, sometimes cough and dyspnea, and which occurred exclusively in the summertime. This disease is now known popularly as hay fever. The cause was not recognized. The clinical description was accurate.

In 1873, in the Pasteur era, Blackley of London demonstrated beyond question that seasonal hay fever, as observed in himself and in others, was due to grass pollen. He showed that when grass pollen was rubbed into a scratch on his skin that an urticarial wheal resulted but that other pollens did not cause such a skin reaction. He also demonstrated that his symptoms occurred only when there was free grass pollen in the air. Later on, Wyman, in Massachusetts, showed that hay fever, occurring in the United States in the autumn, was due to ragweed pollen.

These brilliant and accurate clinical observations demonstrated that pollen was the cause of hay fever and seasonal asthma but the theory received scant attention in the great bacteriological era of Pasteur. After all, why should grass pollen, which is present in the air in England every June, give Blackley and a few of his friends hay fever but not bother other people? Grass pollen appeared to be innocuous so Blackley's work and that of others was widely ignored. A few physicians, usually victims of the disease itself, did accept the pollen thesis and elaborate it.

Just after the middle of the last century Hyde Salter, in the United States, showed that asthma could be caused by animal epidermal dust. The relationship between his observations and those published about the same time on pollen was not recognized.

A number of observers in the older literature noted that such entities as urticaria and infantile eczema occurred commonly in families and often also in the same people who suffered from asthma and hay fever. These scattered observations attracted little notice. It was not widely appreciated in the medical world that there was any relationship between these apparently unrelated diseases and no adequate explanation was offered as to their cause. The substances which apparently caused the disease—for example, ragweed pollen in Massachusetts, grass pollen in London, cat dander and so on—were seemingly innocuous. They could not cause disease. They were literally ignored or thought to be coincidental. These diseases could not be transmitted to other people.

It has been suggested, with some reason, that the brilliant observations of Blackley, Wyman, and others were lost sight of and excited little interest because of the great revolution in medicine brought about by the discovery of bacteria as the causes of disease. Be that as it may, it is interesting that the allergic concept came about as a by-product of the early work in bacteriology.

In 1894, von Behring produced antitoxin for diphtheria. This remarkable substance produced great benefits and lowered the mortality of diphtheria greatly. Yet in a number of unfortunate instances some very mysterious and frequently fatal reactions occurred following the administration of antitoxin. It is now widely known history that the cause of these reactions was acquired sensitization of the patient to the horse serum containing antitoxin.

It was soon found that guinea pigs, which were used for the standardization of antitoxin, could not be used a second time. In some way these animals had become "altered" between the first and second test. This led to the development of the theory of anaphylaxis. If a foreign material,

such as horse serum, is injected into an animal nothing happens. If, after an interval of several days, a second injection of the same horse serum is made into the same animal, very serious reactions occur which are often lethal. Richet advanced the hypothesis that the first injection used up the animal's protecting antibodies so that when the second injection was made the animal had no immune bodies left and reacted violently. For this reason he coined the term "anaphylaxis" meaning the removing of immunity. This theory is no longer tenable, for many reasons, but the term anaphylaxis remains and includes all the experimental phenomena observed in animal hypersensitivity.

Although the term is unsatisfactory, it has remained. In 1907 von Pirquet suggested that another term was preferable and he coined the term "allergy" which simply means *altered reactivity*. It described a condition without implying a cause. Thus the term "allergy," as developed by von Pirquet, means the same thing as the term "anaphylaxis" coined by Richet. However, allergy has come to mean, in common medical usage, a peculiar kind of spontaneous hypersensitiveness seen chiefly in man and sometimes in animals. It has come to mean something somewhat different from the artificial sensitivity produced in animals and which was originally called anaphylaxis.

Anaphylaxis, then, was a phenomenon which was produced experimentally in animals. It occurred only after an animal had been passively sensitized and was specific. Horse serum was apparently innocuous to such animals as guinea pigs on first injection. A second injection ten days later caused anaphylactic shock. Something happened in that ten days to alter the animal's reactivity. It was soon shown that, after the first injection, specific antibodies were formed which would precipitate with the specific excitant. About this time it was also discovered in the laboratory that if small daily injections of the antigen were made after the first sensitizing injection that anaphylaxis would not occur. This phenomenon was known as anti-anaphylaxis.

In 1910, Auer and Lewis showed that guinea pigs, dying of anaphylactic shock, died really of bronchiolar obstruction—that is, from acute asthma. This observation suggested to Meltzer that possibly human asthma was a disease of hypersensitivity or anaphylaxis.

Thus an attractive theory came out of the experimental laboratory to explain the clinical observations of Blackley, Wyman, Bostock, and others on hay fever and asthma. The grass pollen which did not affect most people affected Blackley because he was sensitive to it. The dander of Salter's cat was ordinarily innocuous but his lung was sensitive or allergic to it.

While there were many similarities between human sensitivity and experimental anaphylaxis, certain differences were soon noted. Human sensitivity was spontaneous or constitutional; anaphylaxis was passively induced. Human sensitivity was inherited as a dominant Mendelian character; anaphylaxis was not inherited, although it could be passively passed to the fetus through the placenta. A major difficulty arose from the fact that the antibodies produced in experimental anaphylaxis were demonstrated by precipitation. In man no such precipitable antibodies could be found. Before long, however, Prausnitz and Kustner showed that specific reacting bodies could be passively transferred to the skin of a non-sensitive person by injecting serum from a sensitive person. Thus antibodies were present in human allergy but were not precipitable by ordinary laboratory techniques.

A third term, "atopy," should be referred to. Coca and Cooke coined this word which means "strange disease." They intended it to include spontaneously occurring hypersensitivity in man in contrast to allergy, which was to include all sensitivity phenomena as originally suggested by von Pirquet. However, generally speaking today, the term allergy is used to denote only human hyper-

sensitivity as seen clinically. Anaphylaxis denotes passively and experimentally induced animal sensitivity and also passively induced hypersensitivity in man. In effect, atopy and allergy are now used more or less synonymously. Allergy is the more common word.

In 1911, Noon and Freeman, in London, adopting the idea of anti-anaphylaxis, successfully treated a patient by desensitizing him with grass pollen. They did this by giving very small and frequent hypodermic doses of an aqueous extract of the pollen to which he was sensitive. The effect was good. This was the first use of what is now known as "desensitization" or perhaps more correctly "hyposensitization."

I have thought it useful to go into the history of the development of the theory of anaphylaxis and allergy, not only to illustrate the rather remarkable fact that the theories of etiology, pathology, and treatment of previously misunderstood diseases arose from experimental laboratory work on animals but also that the conception of hypersensitivity applies not only to sensitivity of the lung, namely asthma, but to many other diseases involving other organs of the body. It was now possible to understand why some clinicians had noted a relationship between urticaria, eczema, hay fever and asthma. It was also now possible to understand why environmental factors such as pollen, animal dust, food and so on, seemed to be casually related to diseases which did not appear to be related pathologically. It is particularly important to recognize that the diseases under consideration rarely come to autopsy. The severely reacting tissues return to normal after the reaction subsides and usually there is no visible evidence of the violent tissue reaction which led to such severe symptoms.

Our knowledge of the pathology of allergic diseases has come from autopsy studies on fatal cases, from biopsies, and in particular from direct observation on the experimental animal. From these observations we know that some of the characteristic pathological responses in allergic diseases are:

1. Increased capillary permeability with resulting loss of fluid into the tissues.
2. Increased secretion from mucous glands and cells.
3. Eosinophilia in tissue, in the blood and secretions.
4. Smooth muscle spasm.

These are the fundamental functional pathological changes in the reacting tissue. No matter which tissue is reacting the response is similar, with one or another of these changes predominating. Obviously, if the reactions are long continued secondary changes may occur. Smooth muscle spasm may lead to hypertrophy; mucous membranes may become polypoid, increased mucous secretion may be so marked and so viscid that obstruction to an organ like a small bronchus may occur. The reaction of hypersensitivity may be so severe that death ensues from bronchial obstruction as in the experimental guinea pig, or from asthma in man, or from shock and falling blood pressure in the dog. In man, death can and does occur in severe allergic reactions, usually from respiratory obstruction.

It must be emphasized that the hypersensitive or allergic reaction is highly specific. When a guinea pig is sensitized to horse serum it will react to a second or shocking dose of horse serum but not to some other foreign protein. Similarly in human allergy the individual reacts specifically to definite agents. The grass sensitive patient is not necessarily sensitive to cat dander. The serum of the grass sensitive patient transferred intradermally to the skin of a non-sensitive person will cause that skin to react specifically to grass pollen and no other antigen. It is thought that when the particular antigen enters the body, by whatever route, it reacts with the antibody in the cells of the reacting tissue. The reaction of antigen and antibody produces chemical substances which produce their effect pharmacologically.

(*To be continued next month*).

Caring for the Cardiac Patient

AVIS PUMPHREY *and* MOYRA ALLEN

COMPLETE CARE of the cardiac patient means more than good medical and nursing attention. It involves an understanding of the patient as a whole. This was recognized as one of the cardinal responsibilities of the nurse in discussions held at an institute of the Association of Nurses of the Province of Quebec, meeting in Montreal. Some 90 people from the professions of medicine, nursing, medical social service, public health nursing, and nutrition concentrated their ideas for three days on the problems presented by cardiac patients. Team responsibility was recognized, together with the need for each individual on the team to share his understanding of the patient so that the latter may benefit to the full from care provided.

NURSING CARE

In discussing the nurse's function as a member of the team, it was pointed out that nursing care is continuous while the patient is in hospital so that the head nurse must, of necessity, assume the leading role in the care of the patient as she carries out the doctor's orders.

1. The head nurse must be able to observe and record the patient's progress, the onset of complications, and the therapeutic and toxic effects of drugs. This presupposes an excellent understanding of the disease which the patient has and its treatment.

2. She must have knowledge and experience to care for the physical and emotional needs of the patient. The best way for a student to learn this is to observe the head nurse giving nursing care.

3. She must see herself as coordinator of all members of the team which is caring for the patient. This indicates an understanding of the functions of the team members—the doctor who is in charge of the patient, the nutritionist who is responsible for feeding the patient; the medical social worker who paves the way for the future of the patient; and the visiting nurse who supervises the home care of the patient.

4. She must accept the responsibility to teach others who are learning to be nurses and who, while learning, are caring for this patient.

The nursing care of these patients may be divided into three stages;

During emergency treatment of the acute phase of the disease; during rehabilitation in convalescence; during medical supervision when the patient reports back to clinic.

Let us suppose that a housewife, 45 years of age, is admitted to hospital with acute coronary disease. Her husband is a painter and they have three children — a girl of 14, a boy 11 and one of 9 years. What are the nurse's responsibilities in caring for this patient during the acute period? Her foremost responsibility is to give the heart muscle as much rest as possible until the lesion in the myocardium has had time to heal. Secondly, she must record and report her observations of this patient.

Rest for the heart muscle is achieved by complete physical and mental rest.

1. To obtain physical rest, place the patient in a comfortable position in bed and do not insist on too much attention for the first couple of days. When the patient is awake she may be given a drink or she may be turned. At no time is the patient to exert herself. It should be explained to her that two nurses will turn her as rest is essential at the present time.

2. Rest is achieved by the administration of sedatives which relieve pain and apprehension. The nurse while understanding the necessity for rest, will realize that such sedation has acumulative effect and eventually there may be depression of the respiratory centre with a

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decrease in rate of respiration. She must observe the patient for this toxic sign as well as for constriction of the pupils.

3. The ward should be kept quiet so that the patient may rest; a ward is run for its sickest patient.

4. Mental relaxation is achieved by the quiet reassurance of the nurse in whom the patient has confidence. The nurse accepts responsibility by anticipating any worries which the patient may have—for instance, with regard to her family—so that when the patient is more aware of her surroundings any problems which she has will already be solved, if this is possible.

It is probable that this family will have problems related to maintaining the home now that the mother is ill. If so it is advisable to consult the medical social worker and the nutritionist and, in conference with the father and probably the children, a plan of procedure to maintain the home can be organized.

Visitors should be limited to the husband. However, if the patient is anxious to see someone else it is wise to let the person come for a short while after explaining that the patient must not be upset.

The important observations of the patient which must be recorded at this time would include:

1. Is the patient resting comfortably?
2. Is the patient having pain?
3. Observation of the volume, rate and rhythm of the pulse as this is the most important index of the condition of the heart muscle.

Following the initial stage, rest is still essential. Everything must still be done for the patient and at this time the nurse should explain the necessity for this without alarming her.

1. The nurse must turn, bathe the patient, and change her bedclothes skilfully so as not to tire her. Good care must be given to the back and pressure areas as circulation is poor. Extra care is necessary for the mouth.

2. The patient should be fed small, easily digested meals usually of low salt content. The reason for no salt should be explained. It is wise to tell the surrounding patients not to offer salt. The diet should include things the patient likes providing they are nutritious, high in protein and vitamins. The intake and output is measured to ensure adequate fluids and maintenance of kidney function. Mealtime is recreation for the patient. It is essential that the nurse does not rush her. It is a good idea for the nurse to sit while feeding the patient, preferably on a high stool so that she can reach the patient easily.

3. On the doctor's order a certain amount of passive exercise may be allowed to maintain muscle tone and prevent thrombi formation. This can be carried out most effectively while the bath is being given.

4. A little recreation each day is also necessary—a few minutes quiet talk with her husband, listening to pleasant music on the radio, or having someone read quietly to her for a short while.

When the patient is finally allowed up observation of her pulse, color, general condition, and any pain continues. The nurse's responsibilities in providing care during convalescence are of supreme importance and it is here that nurses often fall short. As the patient is allowed a little more exercise it should be directed toward her rehabilitation, toward helping her to live within the limits of her heart's strength and yet remain a useful member of society.

The nurse can help the patient rehabilitate herself by teaching her to move slowly and never to rush — not running to answer the telephone nor jumping up quickly — and to avoid fatigue and tension of any kind. The nurse must help the family prepare for the mother's return and to accept her limitations.

1. The patient should be shown how to care for herself with the least possible effort:

(a) To bathe herself in bed, later sitting up at the wash basin and, if permitted before she goes home, to get in and out of a bathtub.

(b) To care for her hair easily, probably by having it short. Holding the arms up for any length of time is very tiring.

(c) To dress herself in clothes which are easy to put on—dresses which button down the front so that she does not have to lift her arms unnecessarily

nor have any feeling of suffocation. Shoes should be chosen which give support so that the patient will never have any sense of insecurity or shock.

2. Suitable forms of recreation should be suggested. The patient may have a hobby of her own or the occupational therapist or nurse may be able to help her choose one.

3. Suitable forms of exercise should also be started, such as *walking* and later light housework. The doctor should be absolutely specific in stating the amount of exercise allowed and rest required.

4. The patient must avoid upper respiratory infections and, therefore, should not go where there are crowds. She should avoid extremes of temperature—very warm and cold weather.

At this time the family also needs help to prepare for the homecoming of the patient. The nature of the disease has already been explained to the husband. The children, too, should know a little about the disease, so that each will have some responsibility in maintaining the health of their mother. The children should understand that to keep their mother well they must keep her happy and therefore, they should try not to squabble and should keep the home atmosphere as congenial as possible.

The family should know the exact amount of exercise and recreation which is allowed and the amount of rest necessary.

Many adjustments can be made in the physical environment of the home to save the mother's energy. It may be advisable for the patient to have a bedroom downstairs for a while. Changes may be made in the kitchen — for instance, lowering the cupboards, having tables on wheels, and having the mother sit on a high stool to wash the dishes and iron.

During this period of hospitalization the nutritionist has time to explain to the patient the type of diet which she must follow on discharge.

It is advisable to ask the visiting nurse to see the patient before she leaves the hospital. This enables the nurse to learn about the patient and the patient to know the nurse. She should also visit the home so that she may help the family make further preparations. When the patient reports back to the clinic the nurse must observe and report the condition of the patient — her progress, any signs and symptoms indicative of further coronary involvement or congestive heart failure. The nurse has great opportunities for continued teaching in helping the patient to live within the limits of her heart's strength.

If later this patient shows signs of heart failure and is placed on digitalis therapy, the nurse in clinic can explain the effects of the drug very simply and teach her how to count her pulse, so that if it goes below 60 she can omit the dose. The husband should also be told that if there is undue swelling of the ankles, fatigue and difficult breathing, his wife should come back to the hospital.

If, at a later date, the patient is admitted to hospital with congestive heart failure, the nurse in the clinic is able to make a full report to the nurse on the ward regarding the interim care that has been given.

In summary, from this picture of total nursing care, we must assume that the person nursing this patient is equipped to render this kind of nursing service. If she is to meet these demands then the nurses from whom she learns must themselves be satisfactorily prepared.

Group Planning

The medical team — doctor, nurse, public health nurse, dietitian, and social worker — is a closely integrated group. Although the doctor is, of course, the head of this team, the nurse in the hospital is perhaps, the most important member from the psychological viewpoint. It is she who knows the patient best, who is most closely in touch with him, hears his anxious questions, interviews his relatives and friends when they visit. Her awareness of the patient's problems is dependent on her powers of observation and her sensitivity to his needs — whether he eats well or poorly, whether he rests comfortably or tosses in bed or, indeed, lies rigid with fear. Her daily report to the

doctor is not a routine chore but a human document.

She, more than anyone else on the team, has the responsibility for (1) noting the areas of the patient's anxieties and (2) either meeting his problems herself or seeing that someone else does so if it does not lie within her own function. A simple example might be a patient's enquiry regarding the results of some test. This is often an area of deep concern to the patient. The nurse mentions to the doctor that the patient is worried on this score so that the doctor can relieve the anxiety if he sees fit.

A study of cardiac patients shows two main groupings, in general, of personality patterns. Although these are by no means hard and fast, they are sufficiently repetitive to be worthy of comment. Dr. Flanders Dunbar, in "Psychomatic Medicine" shows that the cardiac patient may fall into one of the following: he may be extremely hard working, seldom taking holidays, almost too independent, and constantly feeling that his personal sacrifices are not appreciated.

> Mrs. Flynn was deserted by her husband shortly after marriage, is childless and supports herself by living with a family. Here she rises at 5:00 a.m., does all the washing and ironing for the parents and five lively children, has no privacy, is expected to act as unpaid baby sitter while the parents go out at night, is never appreciated and, under a surface sweetness, is full of repressed hostility. In spite of the family's understanding of her illness and earnest requests that she "slow down," take rest periods, and be less compulsive in her behavior, Mrs. Flynn was unable to do so. She was happy only when admitted to hospital and kept under regular regime. When later she was transferred to a chronic hospital, she signed herself out and returned to her former unhappy position in the household, apparently driven by a self-destructive-tendency.

The second pattern of behavior often found among cardiac patients is the overly dependent person. This patient is fearful of any exertion, takes greater precautions than those recommended by the physician, resents any attempts to make him become self-supporting, is demanding of his "rights," which always include the right to be supported by someone else. He is a particularly ripe candidate for "hospitalitis."

> Mr. Essex has been a semi-invalid for years and has reduced his wife and grown daughter to the point of exhaustion by his constant demands. He insists on his own room but is afraid of being alone at night, so his wife must come in to reassure him and comfort him several times throughout the hours when she would normally be asleep. He never goes out but gets lonely in the evenings, so that he resents his wife and daughter having any social life of their own. He finds visitors tiring, too, unless they are old friends, and seldom do these come in now because Mr. Essex is only interested in discussing his symptoms. He was admitted to hospital and was overwhelmed with guilt at his past behavior at home, realizing that his wife might wish to put him into a nursing home on discharge, an idea that terrified him. He promised to behave in a more considerate manner if allowed to go home but it is more than likely that he will return to his former pattern of behavior, with little modification.

All cardiac patients are apt to be worried people, fearful of having sudden attacks. The pain they suffer may be related to emotional strains rather than to physical exertion. Fear may become a major disability and psychological invalidism may result. Almost invariably, the cardiac patient needs a supportive relationship with someone to whom he may ventilate his complaints, doubts and fears. His dependency needs to be accepted and recognized with the aim of strengthening his capacities rather than aggravating his weaknesses. It is not sufficient to say firmly, "Don't worry!" and leave it at that. Controlled activity is required. If the area of the patient's worry falls within the competence of the medical social worker, it should always be referred. The social worker knows the community resources — and lack of resources — and is able to help the patient to plan.

If the patient has a family, it is

essential that the whole group be brought into the picture as a positive force. This is often the area in which the public health nurse is particularly helpful. If the nurse on the ward notes that the patient's wife is overly solicitous and is increasing the patient's dependency, she may wish to strengthen her own suggestions to the wife by calling in the public health nurse who will give sustained education to the family group and will see that good continuity of care is carried out. There is often need for preparation of the family *before* the patient is discharged. This is a point that should not be overlooked. Sometimes hospital personnel disregard the fact that discharge from hospital is often as traumatic an experience as is admission, especially for the dependent patient. Here the social worker also can contribute a good deal to both the patient and his family.

The Patient's History

Many doctors make a practice of asking for social histories on cardiac patients. These have many values and often give focus to the activities of the team as a whole. In the first place, they should—if properly prepared—give a picture of the patient's early history. It is interesting how often this shows that in early childhood the patient suffered some sort of traumatic shock, particularly in relation to observing some loved one — not necessarily a relative—undergoing a cardiac attack. There is always the danger of unconscious imitation of the symptoms noted if the patient should himself experience some cardiac dysfunction. This is apt to confuse the clinical picture and may result in the patient going from doctor to doctor and receiving differing diagnoses so that he is utterly confused and depressed. It is often the basis of a functional cardiac illness or a cardiac neurosis. Expert psychiatric care is often needed to restore health.

The social history should also give a fairly clear picture of the personality pattern of the patient. It may be on the basis of this pattern that the medical team will decide to correlate their activities so that all possible means will be taken to assist the patient to live as full a life as possible within his limitations.

It may also be the basis of plans for rehabilitation, since many patients are forced to change their method of earning their livelihood. If this is evident at the point of diagnosis, the doctor may well decide to tell the patient at once. The patient should not, however, be left dangling but should be assisted immediately to think of his future in positive terms, since this will assist in setting the tone of his entire treatment and convalescence. The social worker can be particularly helpful if cases are referred to her at this point. Psychological testing may be indicated, to uncover areas of special competence. It may be possible for controlled retraining to be instituted during enforced bed rest so that the patient's hopes are kept high and his courage and determination to recover not allowed to flag.

Mention was made of the prevalence of traumatic shock in the case history of cardiac patients. This has, of course, a logical corollary in the area of prevention. The medical team, especially the public health nurse, has a responsibility to see that the patient's children's do not, as far as possible, have the opportunity of observing the patient during an acute attack so that they, in turn, may not become potential cardiac victims of the future. Should this happen, the children should be given an opportunity to express their anxieties and work through their fears.

Team Relationships

The importance of an understanding relationship between the members of the medical team cannot be overestimated. The tone of this relationship is often set by the head nurse on the ward. In general the social worker is assured in advance that this relationship will be warm and friendly, that her visits will be welcomed, and that the nurse will do those things that do so much to ensure privacy of interview, even on a busy ward. In some subtle manner all her own,

the nurse usually succeeds in distracting the attention of the other patients so that the particular patient and the social worker are left in an oasis of privacy.

Ward rounds or conferences, consisting of doctor, head nurse, and social worker, do much to ensure the best possible care of the patient as a whole by the entire medical team.

We Serve in the Field of Personnel

MARGUERITE KERR

TWENTY-FIVE YEARS—a quarter of a century—we, who have had a part in the development of the personnel field in industry, have seen real change. From the separate parts —first aid, welfare, employment, and training—there is emerging a unified personnel department under adequate management supervision.

Because there is much to be done yet to bring about the maximum results in business and industry through those engaged in any part of this field, those who serve here need to be alert to essential changes. Such changes may be slight and frequently little noticed yet together they make a valuable contribution.

To serve wisely each person, no matter what that person may contribute in work—a laborer or one in the position of management—must be given the feeling of being a person—not one of a mass of individuals. The Canadian heritage is rooted in Christian democracy. In a Christian democracy each person is responsible for living out in daily life those essential Christian principles of which the moral standards of absolute honesty, purity, unselfishness, and love form the foundation.

In finding the solution of various personnel problems all the units in the field must find a way to work together in harmony. No unit is more important than another and no one person is always right. Solutions come when worked at from the standpoint of *what* is right, not *who* is right. When the possible solution is checked against the moral standards all stand to benefit. It is all part of building a sound business or industry.

One industrial nurse in an eastern Canadian firm was constantly bringing in reports of the difficulties the employees were having in finding adequate housing for their growing families. It was found in many cases that the average worker could not afford to buy a home. Cramped living quarters made it difficult to keep themselves and their families up to par. Not only were they absent due to illness but they often came to work worried about those at home. This affected not only the quality of their work but the way they got along with their superiors and those who worked beside them.

The solution to this problem was found by developing a "Homes for Workers" program. These homes are built for and will belong to the individual with no strings attached. "Thus, men can have their homes and freedom too—in a truly democratic way, with full cooperation between the loan company, the Dominion and Provincial Governments, the industry and the worker—with no monopoly and no one having to take over anybody else's job."

Here was an example of a nurse who saw beyond the round of duty in the ordinary sense of the term. She saw her work in relation to the whole field of personnel—the employees as people, her firm as important in the industrial life of her community—and sought to have a vision for the whole. It is the same kind of

Miss Kerr was a member of the teaching department of The T. Eaton Co. Ltd. of Winnipeg previous to her retirement.

pioneer spirit that dominated our founding fathers and gave us this wide Dominion. Because of their faith in God they were not overcome when difficulties surrounded them. They gave themselves, many without concern for personal reward, that the vision they had might become a reality. It is that giving of self—not out to get—and real dependence on God that is needed in all who desire to serve in the field of personnel.

Dystonia Musculorum Deformans

ANN GERRISH

BETTY, aged 10 years, was admitted by stretcher to our ward during the afternoon of April 24. In my estimation here was a child with unusual intelligence and a sweet and charming personality. Everyone soon found that she had a very lively sense of humor and was fond of practical jokes.

Observed in bed, she appeared to be a thin, poorly nourished girl lying so that her entire body was flexed to the left, forming a sort of semi-circle. Her legs were unusually drawn up and there were jerking, writhing movements of the left toes and fingers and at the left shoulder. There were unexpected occasional contractions of her jaw which caused her chin to move down toward her chest.

This picture of Betty in April, 1951, had only taken two years to develop. Until August, 1949, she had been a "regular tomboy." She was an accomplished horsewoman and her two best friends, as she put it, were springer spaniels. She was also a good student at school. This progressive disease had begun in August, 1949, with her left foot turning out in a peculiar manner. By March, 1950, she could still walk although her trunk was being bent forward and to the left. By December her chest was being sharply pulled to her left side and, with so many spasms, she had trouble getting her breath. Walking was impossible.

By the time Betty reached us she had been to two well-known clinics and tried such drugs as Myanesin, Toserol, Phenobarbital, Artane, and Rabellon, the last named drug being the only one successful in controlling the twitchings. The diagnosis of dystonia musculorum deformans (a disease of the basal ganglia affecting the nervous impulses to the musculature) had been made in Boston. Obviously in Betty's case this had been rapidly progressive and the basal ganglia on the right had been chiefly affected as the left side of her body was the more deformed, although the right side was starting to become affected.

I had the privilege of nursing Betty during her hospital stay. She could do very little for herself. During the last two years she had compensated and changed her mode of activity as she found she could do less. Originally left-handed, she was now accomplished with her right. Ordinary books had been changed to light paper-backed ones that she could hold to read. While in the hospital she discovered that she could manage one of those small weaving sets, so she made reams of small woollen squares, the nurses having the honor of sewing them into an afghan. She amused herself with two stuffed dogs and a monkey named, incidentally, after various house doctors. As I mentioned, she had quite a sense of humor and had various gadgets, such as rings and

Miss Gerrish was taking a post-graduate course at the Montreal Neurological Institute when she prepared this study.

trick flowers filled with water, just waiting for us.

Betty was easy to look after and the nursing care applied was fairly routine. She had a complete bed bath every morning and, if it was a nice day, usually went out on the porch. She was never left alone with the sides of her bed down as one uncontrollable jerk could send her to the floor. Rectal temperature was taken as another safety precaution. Mealtimes were a bit of a problem as her appetite was poor mainly, I think, because it tired her to eat. Propped up with pillows at her left side and back, she could manage with her good hand. I used to to feed the main course to her. She always drank from a feeder as the odd twisting of her lips made drinking from a cup untidy. She wore loose, light cotton pyjamas that were all-enveloping so that she could lie on top of the bed and throw herself around as she pleased. Amazingly, straddling herself on a commode, kept in her room for purposes of elimination, was easier than using a bed-pan in bed.

The only medication was the continuing of Rabellon tablets, one, three times a day with meals, and Phenobarbital p.r.n., to produce sleep. Fatigue certainly made her jerking worse and sometimes the latter helped her to sleep if she seemed "extra jumpy," as she put it.

The point of Betty's visit to the Montreal Neurological Institute was for further diagnosis and perhaps even radical treatment. Two similar cases had been operated on at the Institute with good results. The proposed operation consisted of cutting the peduncles in the right or left hemispheres of the brain, thus interrupting the nerve tracts to the affected muscles. The object was to cause a type of flaccid paralysis of the affected limbs that would abolish uncontrollable jerking but still preserve some voluntary movements. Before reaching such a decision, diagnostic procedures had to be carried out, such as an electroencephalogram and encephalogram.

The pneumoencephalogram was done in the anesthetic room, under Avertin, by rectum. She was given Atropine, gr. 1/150 subcutaneously, and I accompanied her to the anesthetic room and stayed with her until she fell asleep. It was interesting to note that under the anesthetic her extremities were completely flaccid but her twisted body could not be straightened out. The routine spinal puncture was done and about 100 cc. of oxygen injected. The x-rays revealed good filling of the ventricles with evidence of little abnormality except generalized atrophy of the cerebral hemispheres, more marked on the left.

Betty withstood the pneumogram well. Routine post-pneumogram nursing precautions were taken—i.e., her blood pressure, pulse, respirations, and temperature were checked frequently, a bed warmer was applied for about one hour as her temperature was low, and aspirin and Phenacetin gr. 5 were given for her severe headache. As she had fasted beforehand she was only slightly nauseated. After a couple of days she felt herself again.

The next procedure to be carried out was an electroencephalogram. She had experienced this at a former clinic, so knew exactly what was going to happen. In the E.E.G. she was most cooperative while the wires were being placed on various areas of her head and lay quietly while the record was being taken. The report stated that "there were slow waves from the central, frontal and temporal regions usually considered to represent subcortical abnormality involving the upper brain stem." This confirmed what was already suspected — disease of the peduncles in the brain stem. Other routine examinations were carried out, such as examinations of the eyes, blood and urine, which were all normal. The skull and chest x-rays were all within normal limits. The latter, of course, showing marked scoliosis, convex to the right. The Photography Department took over next with still and moving pictures taken for Institute records.

With these various reports, letters

from former clinics, and clinical pictures in front of them, the surgeons and medical men from the various departments in the Institute held a consultation. Obviously medical treatment had failed, yet the operation involved was an exhausting one and the disease was progressing rapidly. The operation might help for some time but, if the good side of her body became involved, further surgery at a later date would have to be contemplated.

There was also the chance that such a procedure might change her personality, which stalled everyone. Betty's courage, wit and charm had been noted by all who came in contact with her and we all knew that without these she would have been a hopeless invalid by now. We also knew that she would need them for the rest of her restricted life. I took her to the clinic so that everyone could see her. Much discussion considering the aforementioned problems resulted. After almost two weeks, the decision was made to operate.

Betty was not told until the afternoon before the day of the operation, so she would not have too long to think it over. She took the news, like everything else, with a stiff upper lip. Even so, as evening drew on she began to be restless so was given seconal gr. ¾ to ensure a good night's sleep.

The next morning Betty had to be up in the operating room by 8:00 a.m. At seven she received a complete bed bath and clean linen was provided to make the operating room bed later. She was also given 300,000 units of Penicillin.

Her head was completely shaved and prepared. To my horror, I discovered that she did not realize the operation consisted of opening her skull. She thought instead that the doctors were going to operate on her left side and straighten it. To have her hair shaved off was the last straw. After it was done, for the first time, the tears started. I shut her door and told her to go ahead and have a good cry. When she had finished I explained, to the best of my ability, why her head had to be operated on. Next came another injection of Atropine gr. 1/150 (she was having a general anesthetic) and then the trip up to the operating room in the elevator. Her lips quivered several times but she did not cry again.

The next unpleasantness that Betty met with was the ordeal of a cut-down, performed by the anesthetist, for intravenous therapy during and after the operation. I stayed with her for this and she carried on a lively conversation with the doctor through the whole procedure. She said "goodbye" with a smile when I left.

The operation, a right subtemporal craniotomy and pedunculotomy, consisted of an incision in the right temporal region. When the areas were reached, stimulation of the peduncles was carried out. Stimulation with an electrical current in the motor strip results in movement of the area of the body controlled by the particular area of cortex. There were none of the sudden jerky movements of cortical stimulations and no clonus. After operation a short summary was made by the surgeon as follows: "The child's movements involved the left side largely. The progress of the disease had been rapid and in spite of that there has been marked deformity of the spine."

When Betty returned to the ward her blood pressure, pulse, respirations, and temperature were recorded every 15 minutes for the first 12 hours, then every hour until they remained stable. Her color was poor on return but improved rapidly with nasal oxygen. Movements of her extremities were carefully noted and it was found that she could move only her right arm spontaneously, though all other extremities on painful stimulation. Both pupils were equal and reacting. Within an hour her color was good and she was responding verbally.

As such a patient must be watched constantly, turned every hour, and given other treatments as required, a special nurse is necessary. Betty had special nurses for the first few days. She did very well and her postoperative course was uneventful. By the first and second day she was tak-

ing fluids well by mouth and aspirin and Phenacetin, gr. 5, q. 4 h. for pain. Her dressing was changed every day, Dakin's strips being over the line of incision to prevent the occurrence of infection; then a dry roller dressing and pliofilm were applied. This was always done in the dressing room.

Betty was a good patient and soon her special nurses were discontinued and we were able to look after her again. The routine was much the same as preoperatively. She had her morning bath and throughout the day was turned from side to side on the hour, special emphasis being placed on how to correct her posture with pillows, etc. Extra care was taken of her skin. Bony prominences or areas where decubiti could develop were massaged with Alphamel. As soon as her dressing was removed her incision was also massaged with Alphamel to prevent adhesions forming between the scalp and skull. She was soon eating a full diet but still had to be helped with it. However, an interesting and important thing to note was that her left side, formerly twisted and constantly jerking, was now quiet. Her shape had not changed but there was a flaccid paralysis right down her left side, even including her lower face. She was much more relaxed and learned to control her movements better. She steadily improved and soon was able to get into a wheel chair, something that she had not been able to do for more than a year. Her back, head, left side and legs had to be supported with pillows. She had it all worked out as to where each one should be placed.

Betty continued to improve. Post-operative E.E.G. studies were done. The report had not changed. Nine days post-operatively the surgeon noted that the left arm had no voluntary movement at the moment but the complete paralysis of the left leg had disappeared. Contractions of the trunk and abdominal muscles were on an involuntary basis, pulling the trunk to the right instead of the left, but curvature was certainly less.

Except for the cessation of the jerkings of her left arm and leg, improvement was hardly perceptible. However, Betty could sit in a chair and voluntary movement was returning. Almost as important, her parents, those wonderful patient people, were very pleased. Her mother especially was looking forward to taking her about with her in a wheelchair.

After almost two months Betty was ready to go home. Before this she had a final physical examination. As was expected, there was slight residual weakness about the left side of her mouth. Spasms were present in the sternocliedomastoid and neck muscles. There were equal abdominal muscle spasms. The right leg muscles at the hip and the arm muscles at the shoulder were in spasm. Leg and hip movement on the left was about one-half as powerful as that on the right and there was right foot-drop. The scoliosis of the spine was now developed with a convexity to the right. However, there were no significant abnormal movements in the left arm and leg and movements of her face were almost symmetrical. Voluntary movement on the right side was good and her spine was straighter than formerly. She could almost sit up using her right hand for support and she could hold her head erect and steady. Pin prick, touch and position sense were all normal.

She was not put in a body cast to help correct deformity but the physiotherapist had been helping her every day with various exercises. Instructions were given to Betty's mother to take home to their Red Cross therapist, who would continue with the exercises.

When the day of her departure arrived she was very excited. I don't think she had closed her eyes the night before. In spite of this, I do believe she was a little sorry to say "goodbye" to us. We were more than sorry to see her go but there were those two dogs waiting and, even more wonderful, one of them was "expecting"!

Newfoundland is 20 times as large as Prince Edward Island but has only one-fifth of that province's crop lands.

Public Health Nursing

The Out-Patient Department

RITA K. ACKHURST

WHEN SPEAKING or writing about an Out-Patient Department of a large hospital one naturally associates the department with the care and treatment of ambulatory patients who are unable to pay private physicians' fees. In the past one might have referred to the "Out-Patient" Department as caring for the sick poor but as time has passed one thinks of the clinics as a means of caring for people whose incomes are in the lower bracket. All races, colors, creeds, or religions are accepted in the clinics and no patients are refused who require medical treatment.

The Out-Patient Department occupies a tremendously important place in the public relations of a hospital. In the case of the Royal Victoria Hospital, Montreal, during an average year about 10,000 new cases are registered as "Out-Patients," with about 60,000 re-visits. The impressions which these individuals receive will have a great influence in forming public opinion about the hospital—favorable or unfavorable as the case may be.

ADMISSION TO THE O.P.D.

Patients who apply for admission to the Out-Patient Department, normally a simple procedure, present many problems, such as economic factors, language difficulties, or the necessity of making a series of appointments with many clinics. It is essential to have a registration department where all patients make their initial application for admission. The functions of this department are varied and many aspects have to be considered:

1. The patient may be referred by: An outside doctor; transfer from indoor department to outdoor department; social agency; or be an eligible applicant accepted without reference.

2. Eligibility of patients for clinics:
(a) Indigent patient, unable to pay any fee—free.
(b) Patient living on minimum pension—10c.
(c) Patient with large family and small income—25c.
(d) Patient with small income (larger majority)—50c.
(e) Patient unable to pay specialists' fees—$1.00.
(f) Patient who is an exceptional case—$2.00.

3. Interviewing and registration:
(a) *Staff:* Trained to interview in a minimum amount of time as patients are usually sick and worried. A bilingual staff is essential in Montreal as a large proportion of the population is French-speaking.
(b) *Financial eligibility:* Personal data and other information must be recorded and records set up with a minimum loss of time and, as far as possible, without arousing the patient's antagonism. This task calls for experience, tact, and sympathy.

APPOINTMENT SYSTEM

Due to the numbers of patients attending the clinics of an Out-Patient Department, an appointment system certainly should in many ways prove a benefit for the patients as well as the staff. Many hours are spent by patients sitting on benches waiting for an interview with the doctor. In the past this was accepted by the patient as a necessary incon-

Miss Ackhurst is supervisor of the Out-Patient Department, Royal Victoria Hospital, Montreal.

venience. Today we try to overcome this waste of time by giving the patient an appointment for a definite hour.

On the first visit a very complete and thorough examination is given, which entails considerable time. In many cases x-rays and specific tests are ordered which necessitate a return visit. We endeavor to have the same doctor see the patient on his return visit. Unless the condition is acute the appointment should be given at a time when all reports are recorded and there is sufficient information so that a diagnosis may be made. This applies to many clinics but in surgery, where accidents and acute surgical conditions predominate, we have to give consideration to these cases and accept them as they present themselves.

In starting an appointment system one of the big factors is educating our patients into the routines which we establish. They frequently don't bother to read the appointment slip which we have given them and present themselves at any time during that day instead of coming at the specified time. If they are unable to attend they think it unnecessary to telephone and cancel the appointment. They also have the idea that if they come to the hospital at an early hour they will be seen earlier, even though their appointment might be for eleven o'clock.

An ideal set-up would be to allow 15 minutes for each re-visit. If the doctors were to arrive on time many patients could be seen in the clinics during the morning and afternoon. Unfortunately, the demands on a doctor's time are many and sometimes he is delayed, immediately upsetting the schedule that has been drawn up. Also, when a doctor is unable to attend the clinic it means his patients have to be cared for by another doctor which makes the load twice as heavy for him.

Many of our doctors devote considerable time to the teaching of medical students, the patients providing the necessary clinical material. In the Royal Victoria Hospital eight final-year medical students are assigned to the medical clinic four days per week for a period of five weeks. Patients coming to the clinic for the first time are assigned to this group where their history is recorded, a complete medical examination given, and certain small tests done. All this is carried out under the supervision of a teaching fellow who in turn is responsible to the chief doctor of the clinic. On his return visit the patient is usually seen by an attending staff doctor.

The appointment clerk must be alert, polite, calm, persevering, and have an understanding of patients as she is called upon to answer many questions. She must also be familiar with the various departments as well as their location as she is expected to direct the patients. It is not always easy to make them understand as many come from European countries and the language problems are acute.

Active Departments

Clinics: The most active clinics come under the medical and surgical departments. Due to the numbers of patients attending these clinics it is essential that they function daily. Their sub-departments have one or two days per week depending on the attendance.

The medical clinic acts as a screening and allocating service. Many patients who have received the full benefits of this service are referred to the other clinics for further investigation. The allergy clinic takes care of those patients who come for tests and injections. This is one of the largest clinics and takes care of the very young as well as the aged. Other sub-departments, such as arthritis, hematology, dermatology, gastrointestinal, diabetic, and endocrinology, have weekly clinics and many patients are regular attendants. With the use of penicillin in the syphilology clinic there has been a great reduction in the numbers of patients who receive treatment as well as a decrease in the number of visits.

The surgical department with its

sub-divisions takes care of regular patients as well as accidents and minor operations. Operating rooms, with an adjoining plaster room, are necessary. These help to alleviate the large amount of surgery that would otherwise have to pass through the general operating rooms in the course of the day. Most of the operations are done under local anesthetic which permits the patients to leave the clinic within a reasonable time.

In the Province of Quebec it is essential that the father sign the operation consent form. This causes considerable delay frequently as a minor must return on the following day for an operation which might have been performed on the initial visit to the surgery. Only actual emergencies can be operated upon with the signed approval of two attending surgeons.

Orthopedics, varicose veins, plastic, neoplastic, rectal, and fracture clinics take care of the specialties which are referred from the general surgery. Otolaryngology and ophthalmology are extremely active clinics. Many children are taken care of who have been referred by the school nurses and various health centres.

Pediatrics, neurology, neurosurgery, and urology are other clinics which have a large attendance.

In a teaching hospital it is essential that sufficient modern equipment is available for the doctors and students who interview and examine the patients. Much time can be lost if there are not enough examining rooms. Each one should be fully equipped. All this is a costly problem but in the final set-up it is of vital importance. A clinical laboratory adjoining the clinic is an advantage as a certain amount of blood work as well as other tests can be taken care of without much loss of time.

Gastric analysis, glucose curves, abdominal paracentesis, pneumothorax, sternal punctures, blood transfusions, and numerous other treatments can be performed on patients with little trouble if the equipment is available. These treatments should be on an appointment basis as space and the assistance of doctors and nurses has to be regulated. Otherwise congestion takes place which is not satisfactory for anyone. The waiting room space in most hospitals is limited and, as many patients have a tendency to bring some member of the family with them when they come to the hospital, it always leaves the impression that the clinics are overcrowded.

Associated Departments

Pharmacy is probably the most important associated department as nearly every patient needs medicinal relief of some kind. Biological products and other specific remedies have tremendously increased the possibilities of alleviating and curing disease. On the other hand they have added greatly to the cost of treatment. Their use calls for a high standard of skill and judgment to secure the best results without excessive cost.

Physiotherapy takes care of a smaller clientele. It also is of great value to certain patients, shortening their period of illness and aiding their rehabilitation.

X-ray, bacteriology, serology, and blood laboratories are essential aids in doing good clinical work, mostly in the field of diagnosis. These services remain in the background as far as the patient is concerned but in our experience are a tremendous value in maintaining efficient medical standards. Some clinicians feel that expensive laboratory aids could be minimized by the use of clinical experience and judgment. We have learned to place a high value on both.

Social service is a necessary part of every modern clinic. It maintains relations with various charitable agencies and the departments of other institutions.

Voluntary workers: Hospitals which have been fortunate in having the assistance of voluntary workers realize the ever-growing service they are rendering. It is necessary to have a director of this department as the demands are great and many workers

Participants in a Speech Therapy Clinic.

are limited in the amount of time they can give to the hospital. This naturally entails a lot of contact work on the part of the director. As the volunteers grow interested in their work it becomes a pleasure rather than a duty they are performing and the assistance they give in the various clinics is not only helpful to the staff but the patient benefits from the extra attention he may receive. A little kindness shown to the patients creates a personal rather than an impersonal relationship that may have far-reaching effects.

Speech therapy: Speech correction is another service which is now being made available through out-patient departments. Although it is one of the newer services which is not automatically included in the program of every out-patient department it is representative of a rapidly growing therapeutic trend toward those disorders which are non-vital in nature. Statistics indicate that 1 per cent of the population stutters, that about 7 per cent of the school population has speech disorders of some kind, most of them non-organic in nature. Qualified speech therapists are scarce in Canada. Their training must be received either in the United Kingdom or the United States. They are kept busy correcting the defective speech of those who can afford private rates but too frequently the rest of the population is either ignorant of the field of speech correction or is forced to look upon it as a luxury item. This condition prevails in spite of the fact that defective speech has a profoundly unfavorable effect upon the total well-being of the individual.

A speech clinic, as a part of the facilities offered by the progressive out-patient department, attempts to reach two goals. First, it makes available to the public a means of correcting such speech disorders as stuttering, articulatory disorders, and delayed speech development. Second, it serves as a member of a team which is concerned with the habilitation or rehabilitation of patients with cleft palate, laryngeal disorders, loss of

hearing, and the many brain injuries involving speech disorders such as cerebral palsy and vascular accidents.

Staff

All clinics have somewhat the same professional set-up. There is a chief of clinic, attending junior doctors, internes, medical students, and nursing staff. The nursing supervisor who has the responsibility of the whole department has many problems to settle in the course of the day. She is familiar with all the departments as well as the individual clinics and is able to advise as well as direct. Her staff of graduate nurses are responsible for the various clinics and the student nurses are rotated through the different clinics in order that they may become familiar with the care and treatment prescribed in each.

Clinical clerks also play their part in the allocating of patients to the different doctors as well as securing indoor records, x-ray and other reports from examinations. This all takes considerable time. Typists also are necessary as the records of the specialty clinics are added to the case history.

Orderlies are essential as there are numerous errands to pathology, bacteriology, and x-ray departments, as well as transporting the seriously ill patients by wheel-chair or stretcher.

Cost of Operation

The cost of operating this department is such that a considerable deficit can scarcely be avoided. During the last year the average fee paid per patient was only 60c. With a net loss of $164,500 and 67,000 patients attending the clinics, this means the loss of $2.46 per visit. It is probably not known by the patients that doctors do not receive fees for their services. The municipal, provincial, and federal authorities do not provide any income for the care of these patients. The tremendous strain on hospital resources can hardly be expected to continue without financial assistance.

Big Strides in Health Made by Ethiopia Since War

Ethiopia, which is virtually without a single native doctor or nurse, nevertheless has developed such a good basic training system for nurses that it is no longer necessary to send girls to foreign schools for this training.

This contradictory situation was revealed by Miss Eli Magnussen, nursing adviser of WHO, on her return to Alexandria from a recent tour of Ethiopia and Uganda in the interest of improved nursing services in the Eastern Mediterranean Region.

First graduates from the newly established Ethiopian nursing school will soon be available, marking a big step forward in the improvement of the country's health services. All that then will be necessary is to develop post-graduate specialization and public health nursing which can be done with WHO aid.

The enormous advances made by Ethiopia since the war can be explained in several ways. The personal interest of the Emperor Haile Selassie, who himself finances a training hospital, is one of them. He has also encouraged nursing specialists from abroad to go to Ethiopia and teach the women of the country.

Much stimulation was also given in the development of nursing in 1948 when the Interim Commission of WHO sent a mission to Ethiopia to aid in starting a Health Personnel Training Program. This work has been enthusiastically continued by the government under the Emperor's leadership and, with the beginning that has been made, there is every reason to believe that the present lack of trained native personnel will be overcome in a few years.

M.L.I.C. Nursing Service

The following are resignations from the Nursing Service of the Metropolitan Life Insurance Company: *Genevieve* (*Lord*) *Cote*, formerly in charge at Three Rivers, this branch now being closed; *Julie Lefrançois* and *Ghislaine St. Gelais* from Quebec City to be married.

Institutional Nursing

The Nursing Team in the Hospital

MARJORIE G. RUSSELL

THE INCREASING DEMAND for nursing services has forced us to seek ways and means of giving the best nursing care possible without wastage of that scarce commodity—professional nursing skill.

It has been declared on many occasions that nurses should be relieved of numerous duties which, while essential to the care of a patient, could be carried out equally well by someone else, leaving the nurse free to give the much needed nursing care for which she has been prepared. Many hospitals are now employing ward clerks to perform a host of such non-nursing duties and have also increased their housekeeping staff to assume various duties which nurses have traditionally carried.

Means are also being sought to relieve the nurse of some of the simple nursing care so that she may have more time to assess the needs of her patients—physical, mental, and social—and to give the skilled nursing care which they require. To do this, hospitals are employing an auxiliary nursing worker, variously known as practical nurse, nursing aide, or nursing assistant*, who has been taught in a school for a period of from nine months to one year for the purpose of giving nursing care to the convalescent, mildly ill, or chronically ill patient. The nursing assistant has generally carried out her duties for this patient on the wards under the direction of the head nurse and has been directly responsible to her. While his physical needs may easily be met in this wise, many of these patients require closer professional supervision than can be given by a busy head nurse whose responsibilities are numerous and varied. At the same time it has been found that some of the more acutely ill patients could have various functions performed for them quite satisfactorily by this assistant were close supervision available.

In an effort to meet the needs of all patients more successfully an experiment known as the nursing team has been developed that has demonstrated two main factors—namely, improved care for patients and greater satisfaction for the members of the team.

In the literature available, the nursing team is generally accepted to consist of the registered staff nurse with one or more nursing assistants working closely together to provide nursing care for a group of patients who have been assigned to their team. The responsibility of the staff nurse is to plan for and provide the nursing that is required for all patients in her group and to direct and supervise the other members of the team. With the team leaders assuming this responsibility the head nurse, in turn, has more time to direct the total program and to carry out her teaching functions.

When planning to introduce the team into the hospital ward, consideration should first be given to several factors which are prerequisites to success. The staff nurse should have an understanding of the need for the assistant nurse and her place in the

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*Nursing assistant is the term used throughout this article.

nursing service. She should have a knowledge of the essentials of team work and the ability and willingness to accept responsibility for the direction and supervision of others.

It is also important that the nurse be thoroughly familiar with the functions of the nursing assistant and that all duties and responsibilities be clearly outlined for all members of the team.

The team may be started in the hospital as a whole, it may be tried on only one ward, or even confined to one team in the ward until its results are evaluated. When the members concerned are familiar with their responsibilities, the head nurse assigns certain patients to the team. These may be either selected patients throughout the ward or those who are in or may come in to a specified ward or number of rooms. This latter method has been tried and is satisfactory as the same team looks after the patient from the time of his admission until his discharge, providing he is not transferred elsewhere. This should not only give him a continuity of nursing, which it is difficult to attain when many nurses enter into his care, but should also provide greater satisfaction to the members of the team.

In delegating work to her assistant the nurse should have a good knowledge of the patient's needs and decide which care she herself should give and which could safely be undertaken by the nursing assistant. Certain kinds of care, which might be given by the assistant for one patient, should be done by the nurse herself for another patient, either because of the severity of his illness or his emotional state. This implies a close supervision and understanding of the needs of all patients no matter what their stage of illness may be. It is likely that the nursing assistant may give most of the care to some patients, the nurse all the care to some, while there will be those to whom both members of the team will contribute jointly.

With the team method it is easier to have the plan of nursing care revolve around the patient rather than around the "medicine list" or the "dressing list."

The nurse gives the medicines, does the dressings and treatments for her patients, except for those that can be safely assumed by the assistant. She should be able to assess the various patients' needs more successfully than when the nursing care program is carried out on a functional basis. The use of the Kardex is an invaluable aid as all the items, including diet, medications, and treatment, are recorded on one card for each patient and are easily accessible for reference.

The team should be able to work together without various interruptions. Special duties outside of the care of patients should be shown on their assignment. In order to avoid many interruptions it may be necessary to have staff members who are not in any team and who would also be available to relieve for days off.

As it is the staff nurse who assigns the work to members of her team, they are directly responsible to her, and only through her, to the head nurse. This gives the head nurse more time for the over-all supervision of her ward. She determines which members will work best in the individual team and assists them with their planning. The success of the team depends to a great extent on the good judgment of the staff nurse, head nurse and department supervisor, on the guidance and supervision given to the assistant, good personal relationships and a clear definition of duties for all.

With the work of the nursing assistant being complementary to that of the nurse the expected results are shown in a better quality and quantity of nursing care for all patients, with each member of the staff doing the work for which she has been prepared.

Attach fruit jar rings under each corner of scatter rugs to keep them from slipping.

Aux Infirmières Canadiennes-Françaises

L'Enfant au Coeur Malade

C. TALBOT

JEANNINE, 12 ANS, est une petite patiente que je viens d'aller chercher à la salle d'urgence car son coeur est très malade. Diagnostic pour le moment: Maladie de coeur d'origine rhumatismale (?).

Je lui enlève ses vêtements avec beaucoup de précautions, la revêt du costume classique de l'hôpital, et l'installe dans le lit près de la fenêtre où je pourrai lui donner un peu d'air frais au besoin.

> La température: 96.3°F. La pulsation est de 124 et intermittente. Légère dyspnée. Les pieds sont froids. Les intestins ont fonctionné hier mais la fillette n'a pas uriné depuis 6 heures.

Sur la feuille d'ordonnance, je prends connaissances des prescriptions suivantes:

> Repos absolu; analyse d'urine; analyse de sang: cytologie, sédimentation; electrocardiogramme; radiographie du coeur et des poumons; diète liquide; glace en permanence, région précordiale; digoxin; oxygène au besoin.

La première chose qui importe est d'installer la petite Jeannine bien confortablement dans son lit et afin qu'elle n'éprouve pas trop de difficulté à respirer, je lui mets plusieurs oreillers qui vont soulever davantage son thorax. Ensuite je lui fais absorber du jus de fruit afin de l'hydrater et favoriser ainsi l'élimination vésicale. Comme ses pieds sont glacés, je m'empresse de les réchauffer un peu en les enroulant dans une couverture de laine pour une vingtaine de minutes.

Tout cela se fait naturellement avec le sourire afin de gagner la confiance de cette petite malade sortie du milieu familial pour se retrouver sur un lit d'hôpital. Si la confiance d'un malade envers son infirmière est nécessaire, je crois qu'elle est primordiale pour le traitement des patients atteints d'affection cardiaque.

Pour le moment, l'état de l'enfant ne requiert pas l'oxygène mais le digoxin doit être administré, ainsi que la glace sur la région précordiale; ce qui se fait sans retard.

Comme la fillette semble un peu fatiguée, il serait bon de la laisser reposer quelques heures; après quoi une civière la transportera au département de radiographie où l'on prendra un rayon-x du coeur et des poumons. Les autres examens—analyse de sang, d'urines, électrocardiogramme—devront attendre au lendemain.

La première nuit est longue, l'enfant dort peu; mais le jour se lève avec l'espérance d'une amélioration. Aidée par le temps, le repos absolu et les bons soins se chargent d'apporter une vie meilleure à l'enfant qui ne réalise pas la gravité de sa maladie.

Si la "maladie de coeur" chez l'enfant requiert des soins médicaux donnés intelligemment, elle exige de l'infirmière une attention soutenue et un dévouement de tous les instants. Son rôle est absolument nécessaire au bon rétablissement de l'enfant.

Celui-ci ignore le danger. Il ne possède pas, comme l'adulte, la connaissance et la gravité de son mal. Le cardiaque adulte sait bien que le repos est la première condition de sa guérison. Il organise sa vie de façon à éviter tout excès de fatigue, toute émotion, toute alimentation qui pourrait déclancher une nouvelle crise. L'enfant, lui, ne sait pas et n'a pas

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Mlle Talbot est élève-infirmière de troisième année à l'Hôpital Ste. Justine, Montréal.

une capacité d'attention assez prolongée pour comprendre la nécessité de sa collaboration avec le médecin. Il faut donc un oeil vigilant qui exerce sur lui une action efficace. Cette action porte principalement sur le repos de la jeune patiente, sur ses loisirs, ses occupations, et sur l'éducation des parents et de l'entourage de l'enfant.

Les petites compagnes qui partagent la salle où vit l'enfant sont plutôt bruyantes au moment de leur convalescence. Elles s'amusent plus brusquement. Et la fillette oublie vite les souffrances de la dernière "crise" et se mêle facilement aux jeux des autres. Le va-et-vient des infirmières, des médecins, des visiteurs, l'atmosphère un peu étourdissant et l'air vicié de la salle aux heures de visites, la chaleur des mois d'été—tout la fatigue à son insu. L'hyperthermie, la rougeur de son facies, sa respiration plus pénible, l'accélération de son pouls, la diapharèse et l'affaissement subit dénotent bien que le coeur est sensible à tous ces facteurs. L'infirmière doit donc faire en sorte que cette surexcitation soit évitée à l'enfant par tous les moyens qui sont en son pouvoir: maintenir dans la salle une atmosphère de calme par une autorité douce et ferme à la fois, pratiquer une aération bien conditionnée, exercer un sage contrôle des visites, etc. Si la chose est possible, elle pourra aux heures de parloir, installer confortablement sa patiente dans un solarium, afin de lui éviter la fatigue et le manque d'air occasionnés par une demi-douzaine d'adultes entassé autour du lit. Elle doit, en outre, faire observer consciencieusement les heures de sieste et le repos hâtif de la nuit.

Quant aux loisirs, l'infirmière verra à ce que les jeux de la petite convalescente ne soient pas trop astreignants et à ce qu'ils soient plutôt de courte durée.

Les occupations de la malade ne sont pas nombreuses à l'hôpital. Toutefois, elles sont bien nécessaires à celui qui y fait un séjour prolongé. Quotidiennement, une institutrice de la Commission Scolaire de Montréal va de lit en lit, donner à chaque convalescent un enseignement proportionné à son âge, au dégré du cours qu'il fréquentait avant son hospitalisation. C'est un précieux avantage pour la fillette qui se trouvera ainsi moins désorientée lorsqu'il lui faudra rejoindre les camarades à l'école. De plus, son psychique en bénéficie, car sa vie d'écolière se continue à l'hôpital, partagée entre les repas, le sommeil, les leçons apprises et récitées à l'institutrice, les devoirs à rédiger, et les heures de loisirs. A ceux et à celles qui peuvent s'occuper davantage, on apprend des petits travaux de menuiserie, les travaux à l'aiguille, etc.

Pour satisfaire chez l'enfant son besoin de lecture, une bibliothécaire, attachée à l'hôpital, s'occupe de distribuer aux petits alités les livres appropriés qu'ils peuvent choisir eux-mêmes. Là encore, l'infirmière contrôle et tempère les activités du patient et varie le tout de façon à ne pas nuire à sa guérison.

L'éducation des parents et de l'entourage de l'enfant atteint d'une maladie de coeur: tâche bien difficile qui demande de la part de l'infirmière beaucoup de compréhension et de psychologie. La réussite dépend souvent du degré d'intelligence des parents. D'ordinaire, plus l'enfant est malade, plus on le visite. On vient nombreux et les conversations animées s'engagent: les problèmes familiaux se posent tour à tour; l'on exprime souvent ses réflexions malséantes sur le médecin, l'infirmière, etc. L'on fait l'historique de la maladie de l'enfant, on pose le diagnostic et le pronostic. Des rapprochements se font avec la maladie de telle autre "petite fille" de la paroisse qui en est morte et l'on parle ainsi sans se préoccuper que la pauvre mioche enregistre tout dans son jeune cerveau. Déjà remplie d'anxiété et d'angoisse devant tant d'injections, de médicaments, d'analyses, de R.X., d'auscultations de la part de tant de médecins, elle en conclut vite qu'elle non plus ne guérira pas. Aussi, faut-il voir le trouble que doit se donner l'infirmière pour calmer les pleurs de sa malade, dès qu'elle se sent moins bien. Elle refuse toute alimentation,

vomit ce qu'elle ingurgite, ne veut pas dormir, et les petites compagnes de s'apitoyer innocemment, "Garde, X... est bien malade." C'est alors qu'il faut avoir recours aux barbituriques, quand un peu plus de jugement de la part des parents aurait éviter toute cette agitation.

Il ne sera donc pas superflu de leur donner mille et une observations au départ de la petite. Leur rôle sera en tout semblable à celui de l'infirmière, sinon plus attentif car la convalescente entre désormais dans un milieu plus actif qui nécessitera davantage de surveillance de la part des parents et de ménagements pour l'enfant malade. Sa guérison n'en sera qu'à ce prix. Si cette éducation des parents est importante durant le séjour à l'hôpital, elle le sera davantage pour les jours et semaines qui suivront son retour à la maison. Là encore le régime de vie sera suivi et la mère surtout devra être renseignée sur la conduite à tenir envers sa petite cardiaque: conduite qui consiste à ne pas être trop sévère envers l'enfant, afin de ne pas la fatiguer mais, par contre, elle doit avoir l'optimisme nécessaire pour éviter le complexe d'infériorité qui peut se développer chez enfant à la suite de sa maladie. A cet effet, une infirmière du service médico-social se rend à domicile assez régulièrement afin de surveiller l'état de la petite patiente et apporter les directives nécessaires.

Avec toute cette collaboration, et tous ces soins, nous osons espérer qu'une guérison sera bientôt possible pour l'enfant au coeur "malade."

In The Good Old Days

(*The Canadian Nurse*—JULY 1912)

"Being requested for assistance on behalf of an aged Nightingale nurse, the executive decided that $30 would be paid to her every December for the rest of her life; which amount maintains her for a month."

* * *

The proposed regulations for the administration of the Ontario Nurse Registration Act included the following:

"*Preliminary education*—Minimum, one year in high school or its equivalent, the superintendent of nurses to decide this. *Professional training*—Three years in a general hospital, with at least 25 beds, where all branches are taught or affiliation for any shortages."

* * *

"Let us have three classes of registered nurses, each class representing a certain set standard of education and professional experience. . . Let us arrange that Third or Second Class registered nurses may become First Class if they so desire, by providing post-graduate courses and securing from our Education Department the necessary extension courses."

* * *

"As a new agent, Radium has been used experimentally in many different conditions; in many, it must be admitted, without fulfilling all the hopes that were first raised. Gradually we have come to understand what we may expect from it. Radium has attained a very definite and important place among therapeutic agents."

* * *

"The duties of the medical inspectors in the school program are to make routine inspections of all children after each vacation—at midsummer, Christmas, and Easter. . . After the routine inspection by the medical inspector, the school nurses make classroom inspections at intervals of two weeks."

Does one's mental speed—that is, the ability to think quickly—increase as one grows older? Yes—up to the age of 27 or 28. Then it very slowly declines through the years.

Trends in Nursing

Visual Aids in Education

THE SWEDISH Nurses' Association reports several showings of medical films for nurses in Stockholm. These have been arranged in cooperation with a central library in Gotenburg, under the direction of a scientific association called Societas Medica. They emphasize the importance of film exchange in educational work.

News from International Council of Nurses' Headquarters

From the *I.C.N. News Letter* comes the exciting news that the *Swedish Women's Journal* has awarded a prize of 1,500 kroners (approx. $375) to Miss Gerda Höjer (president, I.C.N.) for her "outstanding work" in helping to raise the standard of training and social status of nurses in Sweden. All members of the I.C.N. have had the opportunity to appreciate and benefit from Miss Höjer's efforts and interest on behalf of nurses not only in Sweden but also in the international field. The nurses of Canada join with the members of all national associations affiliated with the I.C.N. in extending congratulations to Miss Höjer.

A group meeting of representatives of the national nurses' associations of the western European countries was held in March, 1952, and proved a helpful opportunity for frank and intimate discussions on problems affecting particularly the French-speaking countries, in addition to discussions on exchange facilities for nurses and problems related to them; registration requirements in the various countries; activities of the national Florence Nightingale Committees; as well as matters concerning the I.C.N. Congress in Brazil in 1953.

I.C.N. Headquarters also reports the receipt of a letter from the Australian Nursing Federation enquiring as to the possibility of the I.C.N. Congress being held in Australia in 1957. Something to remember for your future plans! ! !

Belgium: For holiday accommodation in Brussels, information is supplied regarding "Le Club des Infirmières" (The Nurses' Club). All enquiries should be directed to the manageress: *Mme Chaumont, 18 rue de la Source, Brussels.*

Central Schools

R.N. (Apr. 1952) reports that centralization of nursing schools to meet urgent demands for more and better qualified nurses is achieving its purpose in Shreveport, La., and Minneapolis, Minn.

In Louisiana, six hospitals and a state college near Shreveport collaborate in offering students a three-year diploma program, a four-year course leading to an R.N. and B.S., and a two-year program for R.N.'s seeking a B.S. degree. Apparently satisfied with the experiment, the 1950 legislature of Louisiana appropriated $80,000 for 1951 and 1952 to provide students with clinical experience in pediatrics and obstetrics. The centralized program is under the educational control of the college.

In Minneapolis, a similar type of teaching program is offered to four hospital schools of nursing. Costs are met by token payments of 50 cents per bed by each member of the Hospital Council and the balance of the budget is divided among the four schools. Although the council's executive committee administers finances, educational policies are determined by a special nurses' advisory committee.

Studies of Hospital Services

Faced by a serious shortage of nurses, the Health Resources Advisory Committee of the Office of Defence Mobilization announced March

1 the appointment of a special subcommittee to study how to make the best possible use of the available number of hospital workers. It will be the job of the new group to analyze and coordinate for distribution all information possible on how hospital services can be kept functioning at the highest possible level of effectiveness during the mobilization period.—*New York Times.*

Finding the answers to such basic questions as the amount of additional nursing service required in rapidly expanding defence areas; how the available nursing supply can be "stretched" to meet growing needs; and the use of practical nurses or other aides in public health programs is the purpose of a new study planned by the U.S.P.H.S. Dr. Marion Ferguson, assigned to the Division of Public Health Nursing, has been chosen as nurse director of this study to determine the amount and kind of nursing services required to meet minimum public health nursing needs in local health departments.—*R. N.*, April, 1952.

Iceland

National Office has just received a most attractive book "Iceland and the Icelanders" by Helgi P. Briem, illustrated with delightful color photography by Vigfus Sigurgeirsson. This is a gift from Miss Gudridur Jonsdottir who visited Canada last year.

Part-Time Study for Graduate Nurses

In the notification of courses at the School of Nursing, University of British Columbia, we read the following:

> Because of the growing need for nurses in positions for which the basic course does not qualify (e.g., the positions of head nurse, supervisor, public health nurse, etc.) and because nurses unable to arrange for full-time attendance at the university are interested in further study that would broaden their education and prepare them for such positions, the School of Nursing is prepared to encourage nurses to register as part-time students for one or more of the courses regularly offered. . .
>
> Nurses interested in part-time study should arrange for a personal interview with the director of the School of Nursing.

Notes and News from WHO

Nursing education project in Mexico: A six-month training course for nursing instructors was begun in Mexico City on January 13, with WHO technical assistance. This course, which is giving instruction to 30 trainees, includes theoretical and practical nursing, principles and methods of teaching, sociology, mental health, clinical supervision in nursing, nutrition, and advanced Spanish. Students are to return to their own institutions for the last two months of the training to begin "practice teaching" under the close supervision of the instructors of the course.

Upon completion of the training, five of the most capable of the nurses who have attended will be selected for fellowships to enable them to take more advanced study outside Mexico and to prepare them for teaching special subjects, such as surgical and pediatric nursing.

Information booklet available: To meet the need for a ready source of information concerning its fellowship program, WHO has recently published a pocket-size booklet for the use of governments and prospective Fellows. Included in this booklet are details concerning the purpose and objectives of the program, the award and duration of fellowships, selection of candidates and required assurances, travel arrangements, payment of stipend, publications by Fellows, reports, fellowships financed by other sources (UNICEF, TAED, etc.), and form for application.

Nursing Education

Countries represented at the special conference on basic nursing education organized in Geneva recently by the World Health Organization included

Brazil, Canada, Finland, France, India, Switzerland, the United Kinggom, and Yugoslavia.

Because nursing educational authorities, even beyond Canadian borders, are extremely interested in the new system of training which is being evolved at the Toronto Western Hospital, Miss Gladys Sharpe, director of the School of Nursing at this hospital and first vice-president, Canadian Nurses' Association, was invited by WHO to participate in the discussions in Geneva and share her Canadian experiences in nursing education with nursing leaders in many parts of the world, who are watching the results of the Toronto experiment.

Orientation et Tendances en Nursing

Nouvelles du Conseil International des Infirmières

Par le bulletin des nouvelles du Conseil International des Infirmières nous apprenons avec plaisir que le "Swedish Women's Journal" a accordé un prix de 1,500 kroners (environ $375) à Mlle Gerda Höjer (présidente du C.I.I.) pour le travail remarquable qu'elle a accompli en élevant les normes de l'éducation et la position sociale de l'infirmière en Suède. Tous les membres du C.I.I. ont eu l'occasion de bénéficier du travail de Mlle Höjer. Son intérêt et ses efforts ne se sont pas limités aux infirmières de son pays mais aux infirmières du monde entier. Les infirmières du Canada se joignent aux infirmières des autres pays affiliés au C.I.I. pour offrir à Mlle Höjer ses sincères félicitations.

Une réunion de représentantes des associations d'infirmières de l'ouest de l'Europe a eu lieu en mars dernier. Il y eut une discussion franche et intime sur les problèmes affectant particulièrement les pays français d'Europe. L'on discuta également les échanges d'infirmières entre pays, les problèmes s'y rapportant et les exigeances des pays concernant l'enregistrement. Il fut aussi question des activités des comités nationaux de la Fondation Florence Nightingale et du prochain congrès international du Brésil.

Australie—L'on rapporte au C.I.I. que la Fédération des Infirmières de l'Australie s'est informée s'il y aurait possibilité que le prochain congrès international ait lieu en 1957 en Australie. Si vous faites des projets de voyage rappelez-vous de cette invitation!

Belgique—Pour des vacances à Bruxelles le Club des Infirmières vous offre l'hospitalité. Pour renseignements s'addressez à la gérante —Mme Chaumont, 8 rue de la Source, Bruxelles.

Suède—L'on a montré aux infirmières une série de films, grâce à la collaboration de la Societas Medica, que dirige à Gothenburg, la cinématique attachée à la bibliothèque centrale.

Ecoles Centrales

Dans le numéro d'avril 1952, le journal *R.N.* rapporte la centralisation de plusieurs écoles d'infirmières dans le but de préparer un plus grand nombre d'infirmières et aussi des infirmières mieux qualifiées.

En Louisiane, six hôpitaux et un collège d'état, en collaboration, offrent aux étudiantes un cours d'infirmière d'une durée de trois ans, donnant droit à l'enregistrement, et un cours de quatre ans, donnant droit à l'enregistrement et à un Baccalauréat en Science. Le gouvernement de la Louisiane a voté la somme de $80,000 pour les années 1951 et 1952, afin de procurer aux étudiantes une expérience en pédiatrie et en obstétrique. Le programme de l'école centrale est sous la direction du collège.

A Minneapolis, un cours semblable est offert par quatre écoles d'infirmières. Pour défrayer les dépenses du cours, les quatre hôpitaux concernés s'engagent à payer 50 cents par lit et le reste des dépenses est partagé par les écoles. Un conseil des hôpitaux administre les finances mais l'organisation du mode d'enseignement est laissée à un comité d'infirmières.

Etude sur les Services Hospitaliers

A New York un comité a été nommé dans le but d'étudier le meilleur emploi du personnel dans les hôpitaux. Ce comité sera chargé

d'analyser et de coordonner tous les renseignements possible sur les moyens à prendre pour permettre aux hôpitaux de fonctionner à plein rendement et d'une manière efficace durant une période de mobilisation.—*New York Times.*

O.M.S. ET FORMATION DES INFIRMIÈRES

L'O.M.S. réunissait dernièrement à Genève des représentantes des pays suivants: Brésil, Canada, Finlande, France, Inde, Suisse, le Royaume-Uni, et la Yugoslavie. Elles ont étudié le cours de base offert aux infirmières.

Toutes les autorités en matière d'éducation, même en dehors du Canada, sont vivement intéressées dans l'expérience ayant lieu à l'Hôpital Western de Toronto. Mlle Gladys Sharpe, directrice de l'école d'infirmière de cet hôpital, et vice-présidente de l'Association des Infirmières Canadiennes, a été invitée à cette réunion afin de faire connaître l'expérience poursuivie à son école et à prendre part à la discussion.

ETUDE POST-SCOLAIRE POUR LES INFIRMIÈRES

Dans le prospectus présenté par l'Ecole des Infirmières de l'Université de la Colombie-Britannique on lit:

"Un grand nombre d'infirmières sont demandées pour occuper des positions pour lesquelles le cours de base ne les prépare pas (e.g., positions d'hospitalière, de surveillante, d'infirmière hygiéniste, etc.). Ne pouvant suivre les cours réguliers offerts par l'université, elles ne sont pas moins intéressées à se préparer et à faire les études les qualifiant pour ces positions. L'Ecole d'Infirmière de l'université, dans le but d'encourager ces infirmières, est disposée à accepter des étudiantes à temps partiel. Les infirmières, après une entrevue avec la directrice de l'école, pourront s'inscrire à un ou deux cours."

L'ISLANDE

Le Secrétariat National vient de recevoir un beau livre intitulé "L'Islande et les Islandais" par Helgi P. Briem, illustré de magnifique photographie en couleur par Vigfus Sigurgeirsson. C'est un cadeau offert par Mlle Gudridur Jonsdottir qui visita le Canada l'an dernier.

NOTES ET NOUVELLES DE L'O.M.S.

Au Mexique, avec l'aide technique de l'O.M.S., un cours fut organisé pour les institutrices en nursing. Le cours, donné à 30 étudiantes, comprenait: les principes et techniques du nursing; les principes et méthodes d'enseignement; la sociologie; l'hygiène mentale; la surveillance en nursing; la nutrition; et des cours supérieurs d'espagnol. Durant les deux derniers mois du cours, les étudiantes retourneront dans les institutions et feront de l'enseignement sous la surveillance étroite des professeurs leur ayant donné le cours.

Une fois le cours terminé, cinq des candidates des mieux qualifiées seront choisies pour poursuivre des études plus avancées, en dehors du Mexique, afin de les préparer à enseigner des matières spéciales tel que le nursing en chirurgie et en pédiatrie.

LIVRET DE RENSEIGNEMENTS

Afin de répondre d'une manière précise aux demandes de renseignements concernant les bourses d'études offertes par O.M.S., l'on vient de publier un livret, format de poche, à l'usage des gouvernements et des candidats boursiers. L'on trouve dans ce livret des détails concernant les buts du programme de O.M.S., d'autres renseignements sur l'octroi de ces bourses, leur renouvellement, les qualifications des candidats, les assurances, les voyages, etc.

Letters to the Editor

Dear Editor:

I thought you might be interested to know that my *Canadian Nurse* is arriving quite regularly now. My March copy arrived two days ago, which gives you an idea of the length of time it takes to reach here.

I am always very glad to receive it, as it makes me feel I am not far from home. I always have read it pretty thoroughly but out here even the advertisements and announcements of exams are interesting.

You might like to know also that, a couple of months ago, one of our Burmese Sister Tutors, Ma Mya Kyi, decided to let the preliminary class stage a variety concert and asked me if I could find a "nice poem about a nurse" for one of them to recite. I hunted through my *Journals* and found a short one which was recited at the concert in English, with much enthusiasm and feeling. The concert was a great success.

—M.J.G., *Burma.*

C.N.A. Resolutions

WHEREAS, The Demonstration School Administration Committee has been functioning for six years and will be dissolved at the first Executive Committee meeting of this biennium; and

WHEREAS, The Metropolitan School will be terminated in October, 1952; and

WHEREAS, There have been so many people who have contributed in one way or another in this experiment which the Canadian Nurses' Association has conducted in Windsor; therefore be it

Resolved, That the Canadian Nurses' Association, in convention, instruct the General Secretary to take the appropriate action to acknowledge this Association's gratitude and sincere thanks to the organizations, governmental departments, honorable ministers and individuals as well as the many people in Windsor who have made this school possible.

* * *

WHEREAS, The need for experience in psychiatric nursing has been emphasized in the Report of the Evaluation of the Metropolitan School of Nursing, and is an important aspect of the basic preparation of the professional nurse, a need that cannot be met without satisfactory practice fields in psychiatric hospitals; therefore be it

Resolved, That every effort be made to establish practice fields and to encourage the inclusion of psychiatric experience in the basic professional course.

* * *

WHEREAS, It is recognized that the past biennium has been one of progress by the Canadian Nurses' Association in the field of research; and

WHEREAS, The need for continued expansion in the area of research in nursing is evident; therefore be it

Resolved, That the Nurse Research Assistant who was associated with the Study of Head Nurse Activities be asked to direct the preparation of a Manual, outlining simple research procedures which would assist and encourage nurses to analyze and deal more effectively with nursing service problems; and that, in the preparation of such Manual, advice and assistance be sought from the Research Division of the Department of National Health and Welfare;

THAT a letter be sent to the Research Division of the Department of National Health and Welfare, expressing our appreciation of the contribution which this Division is making toward the improvement of nursing service in Canada through the conduct of the Study of Head Nurse Activities, and our hope that this study may be followed by further research in the field of nursing service;

THAT the Executive Committee of the Canadian Nurses' Association continue to foster and guide nursing research programs that will increase our knowledge and provide sound scientific information for the nurses of Canada.

* * *

WHEREAS, The Ottawa Civic Hospital Board of Trustees has generously made available the resources and facilities of that institution for the Head Nurse Study; and

WHEREAS, The Board of Trustees, Administrator, and Director of Nursing have wholeheartedly supported the research work on this study and have expressed readiness to participate in further activities of this kind; therefore be it

Resolved, That appropriate letters of appreciation be sent.

* * *

Be it Resolved, That the incoming Committee on Student Nurse Activities of the Canadian Nurses' Association be approached concerning the promotion of inter-provincial contacts between the students of the schools of nursing of Canada.

* * *

WHEREAS, The nursing profession has a responsibility for the standard of nursing care in psychiatric hospitals; and

WHEREAS, The whole situation of the training and status of personnel for the nursing care of psychiatric patients is confused and involved; and

WHEREAS, Professional nurses who are responsible for the nursing service in psychiatric hospitals are seeking assistance from the Canadian Nurses' Association; therefore be it

Resolved, That a special committee be appointed to study the problem of the preparation of non-professional psychiatric nursing personnel, and that provision be made for bringing the committee together to work on this problem.

* * *

Be it Resolved, That the functions of the former Canadian Florence Nightingale International Foundation Committee be under-

taken by a sub-committee of the Educational Policy Committee, to be known as the Florence Nightingale International Foundation Sub-committee.

* * *

Resolved, That a sincere vote of gratitude and appreciation be extended to all those whose time and talent have made this meeting a most beneficial and memorable occasion:

1. To the President, A.N.P.Q. Miss A. Martineau; Vice-President, Reverend Sister Mary Felicitas; the Secretary-Registrar, Miss M. Street; and Mademoiselle F. Verret and the members of the Arrangements Committee, for their very cordial welcome and generous hospitality.
2. To the management of the Chateau Frontenac, Mr. J. Jessop and his staff.
3. To the Honorable Onésime Gagnon, Minister of Finance, and the Deputy Mayor, Mr. Paré, for their very friendly welcome.
4. To Monsieur l'Abbé Emile Hudon for opening our meeting with his gracious invocation.
5. To Madame F. Surveyer and Miss Rose Hamelin who undertook the preparation and arrangement of the General Interest Sessions and to all those who contributed so generously in time and effort to these sessions.
6. To the Mother Superior, Hôtel-Dieu, who so graciously served as hostess to the student nurses and who also presented the Pageant.
7. To Laval University for their gracious reception of the Executive of the Canadian Nurses' Association.
8. To Monsieur l'Abbé A. Maheux for his scholarly address as a memorial to Mary Agnes Snively.
9. To the Press for their generous coverage of the Biennial Meeting.
10. To the Exhibitors for their interest and support and to the J. B. Lippincott Co. for the comfortable relaxation afforded in the beautiful surroundings of the Lippincott Lounge, Quebec City.
11. To The T. Eaton Co. for their contribution in the printing of the programs of the Biennial Meeting.
12. To the General Secretary, Miss Gertrude M. Hall, to her Acting Assistant, Miss M. Walker, to Mrs. A. N. Clerk, Convention Manager, and to the staff of National Office for their untiring efforts in the best interests of the Canadian Nurses' Association.
13. To Miss Doreen Bédard, our French translator, for her contribution to the Association in its endeavor to bring all aspects of these sessions to our French-speaking members.

* * *

Be it Resolved, To thank the Canadian Nurses' Association for the bilingual meetings held this year. The French nurses present to you their deep appreciation and wish to ask that arrangements be made again for conducting the meetings in the two languages.

* * *

Be it Resolved, That *The Canadian Nurse Journal* publish and emphasize the French presentation of the articles and reports.

* * *

WHEREAS, It is with deep regret that the members of the Executive accepted the resignation of our devoted General Secretary-Treasurer, Miss Gertrude M. Hall; and

WHEREAS, All the members of the Canadian Nurses' Association wish to express their most sincere gratitude for the untiring effort and zeal she has brought to the affairs of the Association, for her able administration of the National Office and the enormous amount of work she has performed in spite of restricted personnel, for the invaluable help she has so kindly given to all national committees, provincial associations, and individual members; therefore be it

Resolved, That a very cordial vote of thanks and of sincere appreciation be extended to Miss Gertrude M. Hall, with warmest good wishes for continued success and happiness in all her future undertakings.

* * *

The above resolutions were passed at the 26th Biennial Convention in June, 1952.

Let us reflect that the highest path is pointed out by the pure ideal of those who look up to us and who, if we tread less loftily, may never look so high again.—N. HAWTHORNE.

Student Nurses

Intestinal Obstruction

BEATA TOMANDER

MRS. GILL, born in 1891, spent a normal, healthy childhood, with the usual communicable diseases such as measles, whooping cough, etc. When 14 years of age she had an attack of severe abdominal pain, which was thought to be due to appendicitis. As the pain subsided in a few days, operation was not performed.

Mrs. Gill has been married twice, her second husband being a farmer. She has had four children who all are living and well at present. Her father died from pneumonia when she was only five years old. Her mother lived, healthy and active, until she was 93. Shortly before her death a large growth seemed to be developing in her abdomen. No surgery was performed so the actual cause of her death was not known.

The second marriage, according to Mrs. Gill, was a "big mistake." The harmony and happiness of the family was greatly disturbed. As the years passed family life became more and more difficult. Probably due to her unhappy home life the patient seemed to be inclined to look on life rather pessimistically and overestimate every care that was given during her stay in hospital.

About three weeks previous to admission, Mrs. Gill started to have abdominal pains which grew more severe as the days passed. At that time she also was unable to have regular and normal bowel movements, so she had to use enemas and laxatives daily. Finally she was admitted to hospital. Her temperature was slightly elevated on admission. She was put to bed and an enema was given. She was allowed to go to the bathroom. Only fair result was obtained from enema: the solution was returned with little fecal matter. After the enema she felt more comfortable. At bedtime nembutal gr. 1½, as a sedative and hypnotic, was given and she slept well that night.

A catheter specimen of urine was found to be negative for albumin as well as for sugar. Blood also was examined. The report showed hemoglobin was 95.7%, R.B.C. count was 4,820,000.

Perineal and abdominal preparation was given since it was decided to do an exploratory laparotomy. The provisional diagnosis was intestinal obstruction. An enema was given at bedtime with only fair result as on previous day.

The usual morning care was given, followed by morphia gr. 1/6 with atropine gr. 1/150 as preoperative sedation. Mrs. Gill was catheterized before being taken to operating room.

The left tube and ovary were removed and colostomy was done. It was decided that the growth would be removed later. During the operation penicillin 300,000 units, streptomycin 1 gr., and sulfathiazole 5 gr. were put into peritoneal cavity and 1,000 cc. of 5% dextrose in normal saline was given intravenously to prevent dehydration. Blood transfusion of 500 cc. of whole blood was started also.

When Mrs. Gill was returned to her room, she was already conscious. Her condition was good, pulse was strong and regular, respirations normal. Shortly after her return morphia gr. 1/6 was given to relieve severe abdominal pain. She slept for several

Miss Tomander is a senior student at the Moncton (N.B.) Hospital.

hours. In the afternoon sips of hot water and ginger ale were given. At bedtime morphia gr. 1/6 was repeated. She was able to void, which greatly relieved pain in the abdomen. She spent a good night.

On her first day after operation Mrs. Gill complained of feeling nauseated so demerol 100 mg. was given, instead of morphia, to relieve pain and discomfort. Streptomycin, ¼ gr. q. 4 h., and penicillin, 400,000 units b.i.d., were started. These were to be given daily as antibiotics.

Hot, clear, liquids were given freely during the first week. The diet was changed gradually until the 10th day when she was put on a bland diet. The patient was encouraged to move her arms and legs frequently and thus to improve blood circulation and muscle tone. She also was encouraged and helped to turn on her sides rather than lie on her back. Most of the time she was kept in semi-Fowler's position where she seemed to be the most comfortable.

The patient complained of severe gas pains so a rectal tube was inserted which brought her relief. On the third day the colostomy dressing was changed for the first time. After that it was changed twice daily. Each time, after the skin was cleansed, a vaseline dressing was applied to prevent the surrounding skin from becoming irritated by being in contact with fecal discharge from colostomy. Montgomery tape dressing was used to avoid irritation of the skin by frequent changing of adhesive tape.

On the fourth day, the colostomy was irrigated with warm saline solution. Mrs. Gill felt greatly relieved after the irrigation as a considerable amount of flatus was expelled. On that day her temperature was elevated to 100.6° F. It persisted for next eleven days, reaching its peak of 102.8° F. on the 12th day after operation.

In spite of her elevated temperature Mrs. Gill's general condition and appetite seemed to be improving daily, with the exception of the sixth day when she complained of having an upset stomach and was unable to void. This caused great abdominal distention and she felt extremely uncomfortable. All nursing measures were tried to make her void and liquids were given freely. Finally she succeeded in voiding. After the bladder was emptied she spent a very good night.

On seventh day Mrs. Gill was allowed to sit up on the side of her bed for a few minutes. She felt fine, except for being a little tired. Starting the eighth day, the colostomy was irrigated with warm saline solution daily. All clips and sutures were removed on the ninth day. The dose of streptomycin was reduced to ¼ gr. q. 6 h.

Though Mrs. Gill was regaining her physical strength, her psychological state was neither contented nor cheerful. Every time her colostomy was irrigated she seemed to go through mental agony. She was very conscious of the foul odor which came from the colostomy. All the nurses had to exercise great care not to mention that the odor was so objectionable. To lessen the foul odor she was given one Sudroma tablet once daily over a period of ten days. Since the preventive effect of these tablets seemed to prove unsatisfactory and their taste was sickening to the patient, they were discontinued.

Since Mrs. Gill's general condition seemed to be fairly good it was decided to operate on her again 19 days after first operation. The colostomy was irrigated preoperatively and all other routine care was given.

Spinal anesthetic and pentothal sodium were used. Penicillin 900,000 units and streptomycin 3 gr. were put into the peritoneal cavity during operation. Glucose and saline, intravenously, were given during the operation. Whole blood was also given (i.v.) since her hb. and R.B.C. were much lower than before the first operation—hb. 73% and R.B.C. count, 3,950,000.

Resection of the sigmoid and pelvic colon, including the lower end of rectum, was done. A cigarette drain was left in the incision to allow drainage. What was thought to be carci-

noma of the rectum proved to be diverticulosis with abscess. Microscopic study of the resected bowel revealed no malignancy.

Still under general anesthetic, Mrs. Gill was returned to her room. She recovered consciousness very shortly. Her condition was good, pulse strong and regular, respiration normal. Morphia gr. ¼ was given for three days to relieve pain. Hot clear liquids were given freely and were taken well by the patient. On tenth day after operation she was put on a bland diet. During the first few days there was a large amount of purulent waterish discharge on the dressings so they had to be changed frequently.

In the days that followed the second operation Mrs. Gill seemed to be mentally very much upset and worried. As a sedative, phenobarbital gr. ½ was ordered to be given t.i.d., p.c. Also phenobarbital sodium gr. 2 was ordered hypodermically at bedtime. The use of this sedation proved effectual and the patient seemed to be much more contented and rested better at nights.

On the 11th day the cigarette drain and all clips and sutures were removed. It was found that about three inches of the incision had not closed. From that opening a large amount of purulent foul-smelling discharge escaped. The infection was thought to be due to colon bacilli. Hot boracic compresses were applied to the incision several times daily over a period of ten days. Once daily the incision was irrigated with streptomycin (1 gr.) solution and after irrigation aureomycin ointment was instilled. The colostomy was irrigated daily and vaseline dressings applied as after the first operation. Special care was taken to keep the abdominal incision from coming into contact with fecal discharge from the colostomy. On days when there was much discharge from the incision it was inclined to drain down on the perineum in spite of dressings applied. For several days perineal care was given to keep the perineum from becoming irritated.

Along with other medications vitamin C, t.i.d., p.c., was started to hasten the healing process. Mrs. Gill's appetite seemed to be improving with every day, especially after the incision had been draining for several days and the fever had subsided. In spite of the open incision she was allowed to sit up in a chair for as long as 30 to 45 minutes daily. Before getting up a scultetus binder always was applied to support the abdominal muscles. She was encouraged to move around freely in bed to help drainage from the incision. For short periods daily, supported by the scultetus binder, she would lie on her abdomen to allow for better drainage.

Mrs. Gill needed a great deal of encouragement from the nurses to get her over the inferiority complex she seemed to have developed because of her colostomy. Her unhappy home life and financial difficulties seemed to be another cause of her worries. And, above all, she believed that she had cancer and that it was the reason why her incision was open and draining. A serious talk with the surgeon, who assured her that no malignancy was found, freed her from fear and worry. Her mind seemed to be so greatly relieved from that day on, she seemed to enjoy talking to other patients and meeting them. She even seemed to enjoy her walks in the hall—"in public" as she called it. More hope for speedy recovery was added when a month after her second operation the incision was free of discharge and irrigations were discontinued. Eventually the incision was sutured with silk to keep it together and to speed healing.

New Use for Aluminum Foil

Wrap good woollens, after washing or brushing, airing and spraying with good moth repellent. This heavy foil is almost self-sealing and, when heavily creased along open edges, will give sure-seal against the entry of moths.

In Memoriam

Margaret Ann (Cruikshank) Brown, who graduated from the Toronto General Hospital in 1893, died at Port Robinson, Ont., on December 28, 1951.

* * *

Della (Hoyt) Dakin, who was for many years night supervisor of the Saint John General Hospital, N.B., died in Digby, N.S., in April, 1952, after a lengthy illness. Mrs. Dakin had also worked in a number of centres in the United States.

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Edith Dowdall, who graduated from the Kimberley Hospital, South Africa, in 1887, died in Fort William, Ont., on April 15, 1952, at the age of 92. Mrs. Dowdall served as a nurse during the siege of Kimberley during the Boer War.

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Anne Margaret Ebbs, a graduate of the Lady Stanley Institute, Ottawa, died on April 25, 1952, in Ottawa.

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Beatrice Ada (Dufton) Elliott, who graduated from Victoria Hospital, London, Ont., in 1917, died in Sparta, Ont., on April 21, 1952, after a year's illness. Mrs. Elliott was a member of the supervisory staff of the Toronto East General Hospital for 17 years. Nine years ago she moved to St. Thomas and engaged in nursing there until she became ill.

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Josephine Foran, who received her nurse's training in Ogdensburg, N.Y., but who had engaged in active nursing in Ontario and Quebec until her retirement 24 years ago, died in Aylmer, Que., on May 9, 1952, at the age of 89.

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Harriet Rosina Hamilton, who graduated from the Victoria General Hospital, Halifax, N.S., in 1895, died in Halifax on April 29, 1952, at the age of 90. Miss Hamilton had spent the active years of her nursing career in the United States.

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F. Gertrude Harwood died in St. Thomas, Ont., on May 14, 1952. Miss Harwood had engaged in private nursing for many years in London and Woodstock, Ont.

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Florence Gertrude Leadley, who graduated from the Toronto General Hospital in 1917, died suddenly in Hamilton, Ont., on January 30, 1952.

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Nettie Johnstone (Bunker) Megelin, who graduated from the Oshawa General Hospital in 1923, died recently in Chicago, following a coronary.

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Claribel Gladys (Robertson) Morgan, who graduated from the Memorial Hospital, St. Thomas, Ont., died on May 14, 1952, at the age of 44. Mrs. Morgan had served on the staff of Memorial Hospital for many years.

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Lexie Robina (Gilchrist) Parker, a member of the first graduating class (1902) of Aberdeen Hospital, New Glasgow, N.S., died in Pictou, N.S., on April 12, 1952, at the age of 83. Prior to her marriage Mrs. Parker engaged in nursing in the United States.

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Sylvia Willett, who became district nurse in Spruce Grove, Alta., in 1908 and who served that area for many years, died in Edmonton on May 7, 1952, at the age of 84.

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Bessie B. Yule, who graduated from the Toronto General Hospital in 1926, died in Toronto on February 4, 1952.

Commercially canned tomatoes and tomato juice contain approximately the same amount of vitamin C. Modern commercial methods are designed towards maximum retention of this vitamin during processing and canning.

The ***color of oranges*** is not a sure guide to their quality. Many oranges are dipped in, or sprayed with, a harmless vegetable dye solution. This gives the outer skin the deep orange color expected by the consumer. The law requires all oranges, treated in this way, to be stamped "Color Added."

Book Reviews

Ward Management and Teaching, by Jean Barrett, R.N., M.A. 399 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 1949. Price $4.40.

Reviewed by Gertrude M. Hall, General Secretary-Treasurer, Canadian Nurses' Association.

When Jean Barrett, professor of Nursing Education and director of the Department of Nursing Education of Syracuse University School of Nursing, wrote this book for students preparing for head nurse positions she made a valuable contribution to nursing literature. The author is a teacher who has personally experienced every step of the trail over which these young nurses must travel if they are to become fully qualified.

The functions of the head nurse are discussed throughout in relation to the main objective—attaining high standards of nursing care. The book is divided into segments which deal specifically with the head nurse as a person, her relationships to the patients, and her full responsibilities and place in the total hospital scheme. The teaching functions of the head nurse are clearly set forth and emphasis is placed upon a recognition of these functions by all participating departments of the hospital and school administration.

The author shows how good administration can be used to organize the activities of the ward, to improve the care of patients, and to promote the optimum performance of ward personnel.

A number of excellent features add to the usefulness of this text. Forms, records, and devices used by the head nurse are presented. Annotated bibliographies are included at the end of each chapter.

While the text is intended primarily for the use of students, it should also prove helpful to hospital administrators who, by reading it, will better understand the scope of the duties inherent in the position of the head nurse and the kind of administrative support that is needed in order to hold the standards of ward management and teaching on a high level and in making the position of the head nurse of more intrinsic value to the institution.

After reviewing this excellent text, one is impressed with the need for the head nurse to be given the opportunity to put her knowledge and ideals into practice; a sufficient staff of competent assistants must also be provided. It should help those now serving as head nurses to find encouragement and stimulation in their work and should provide them with useful suggestions for improvement.

A Guide to Professional Nursing—Nursing, Midwifery, and the Allied Professions, by Bethina A. Bennett, O.B.E., S.R.N., M.C.S.P. 231 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 1951. Price $3.75.

Reviewed by Helen E. Penhale, Director, School of Nursing, University of Alberta.

Mrs. Bennett has presented a comprehensive study of nursing in Great Britain. She has included detailed information on a career in nursing—the educational requirements and the preparation for various fields of training such as fever nursing and mental nurse training. Post registration training and opportunities in nursing, midwifery, and the services allied to nursing are clearly presented.

The object in writing the book, as stated by the author, was to provide the principals of schools and those to whom is entrusted careers, up-to-date information on training regulations and the scope of various employment opportunities available in Great Britain and in other countries.

The book is written in textbook style with many headings and sub-headings. The index is very comprehensive. There are 33 illustrations which portray the nurse in the various employment opportunities open to her. The appendices would be of especial value to the British nurse. They cover a description of the restbreak houses, convalescent and holiday homes, a list of books of general interest to students preparing to train, and the addresses of various organizations frequently used by nurses.

One feature of the book of interest to Canadians is the section on professional organizations such as the International Council of Nurses. The presentation is factual and brief, hence fails to give the reader an appreciation of the value of membership in the international organization.

While the book is interesting, its use as a reference in Canadian schools is limited.

Better Nursing—A Study of Nursing Care and Education in Washington, by Jean A. Curran and Helen L. Bunge. 174 pages. Burns & MacEachern, 165 Elizabeth St., Toronto 2. 1951. Price $3.50.

Reviewed by A. Dorothy Potts, Director of Nursing, General Hospital, Belleville, Ont.

This book is a compilation of surveys in nursing care and nursing education conducted by two nationally known medical educators, with the assistance of a committee of persons representing the medical and nursing profession and hospital administration. Its object is to determine the cause of "shortages and shortcomings" of nurses and nursing; to criticize present practices which affect the supply and demand; and to offer recommendations to alleviate both present and future conditions. It is a study of nursing in Washington State but the problems discussed are those common to nurses and nursing in Canada, as well as the United States. The recommendations that are offered can likewise be applied in our own situations.

The book is divided into five sections. Section 1 deals with specific recommendations by Dr. Curran and Dean Bunge. Recommendations based on findings of studies on nursing care and nursing education in Washington are outlined in Sections 2 and 3. Section 4 deals with a summary of problems in nursing care and education and Section 5 a summary and review of national emergency situations.

Outlined in Section 1 are 22 positive steps recommended to improve nursing education and nursing service. The authors hope that "all will serve as 'thought-starters' and that some, at least, will be springboards to action."

Some recommendations made by Dr. Curran are: (1) Closer cooperation of all persons concerned with both education and service through participation in committees, panels, round-table discussions, etc., not only in the institutions but also in state medical, nursing and hospital association conventions. (2) The promotion of an understanding of the allied professions in the health field. (3) Restudy of the existing curricula of schools to determine (a) if they are producing the types of nurses needed today; (b) allowing growth of individual talents; (c) providing continued education after the "training period." (4) Strengthening practical nurse schools. (5) Stimulating team-work development, etc.

Dean Bunge carries on with further recommendations concerning improved nursing service. Her suggestions regarding "personalizing nursing care" should be helpful to all interested in establishing good hospital and public relations. She recommends a study of the functions of all hospital nursing personnel with a view to making more effective use of individual skills and abilities. She discusses the "team concept of nursing"—what it is, what its values are in improved patient care and in personnel satisfactions.

As previously stated, Section 2 deals with the studies made in the State of Washington. These are: (1) To determine the actual need for nursing service and the existing resources for meeting this need. (2) Made by the State Medical Committee, to determine what doctors felt about nurses and nursing education. It is interesting in that it is apparent that we have not yet made our problems clear to the medical profession. Their answers to a question regarding "modern methods of education" indicate that 75 per cent feel that nurses are not "adequately prepared in the care of the sick." Eighty-three per cent felt that "liberalizing" the educational requirement for enrolment would overcome the present shortage of nurses. Recommendations offered by the Committee suggest that doctors feel they should be permitted more say in educating nurses. Further studies are to be found in this section.

There are 56 pages of appendices. These include results of the studies mentioned above plus such data as enrolment in basic nursing programs; numbers of students receiving experience by affiliation, weekly class and practice hours, etc.; recommendations of the Report of Nursing Study of 1950, which provides much food for thought concerning "a citizen and nurse cooperation"; the responsibility of the advanced nursing educational programs, etc.; detailed outlines of the questionnaires sent to nurses and doctors, their suggestions and recommendations. Also there are reports of visits made by the authors to selected hospitals in Washington in which they interviewed superintendents, directors, and staff nurses and gained their comments and recommendations (which are also entered in the appendices).

The writer of this review found the book to be educational with respect to the manner in which a survey is conducted and the data is assembled; helpful in the recommendations which were offered. It was well written and easy to read. She recommends that the book

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be studied by directors of nursing service and nurse education, by hospital administrators, and the faculties and students of advanced nursing education programs.

Sociology and Social Problems in Nursing Service, by Gladys Sellew, B.S., R.N., Ph.D. and Paul Hanly Furfey, Ph.D., LL.D. 391 pages. McAinsh & Co., Ltd., 1251 Yonge St., Toronto 5. 3rd Ed. 1951. Price $4.25.

Reviewed by Sister Columkille, B.Sc., Supt. of Nurses, St. Paul's Hospital, Vancouver.

The objectives of the co-authors as stated in the preface, "to select from the vast field of Sociology facts and theories which are of particular importance in nursing," are very capably sustained throughout the book.

The first part of the book gives a comprehensive picture of the historical background of society and social trends in general, while the second part of the book shows the interrelationship which exists between society and nursing. It also demonstrates the great necessity for understanding and cooperation between these two bodies.

The subject matter, ably treated as it is in the unit system, has its value greatly enhanced by excellent diagrammatic tables and potent illustrations. The authors are consistent in their philosophical principles.

The topics for discussion at the end of each chapter should facilitate the study for the student and the table of contents and bibliography, in such detail, are added assets.

I feel that this book would be most useful as a textbook for student nurses as well as an excellent reference book for graduates, both in social work and in nursing, because as stated in the chapter on The Family: "The reason nurses study sociology is not to learn set rules governing social behavior—for no such rules exist—but rather to understand the social background of those people whom they know as friends, meet professionally, or nurse in the hospital or home."

One point I would like to have seen stressed a little more forcibly through the book is greater emphasis on the motivation for nurses in social service. The authors are fully cognizant of the obligation that all individuals are under to contribute respectively to the well-being of the social organism but much more so are nurses.

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Antibiotics and Burns

Modern antibiotic drugs, in addition to combatting scores of dangerous infectious diseases, are proving valuable to physicians in the treatment of severe burns, recent medical reports indicate.

Administration of antibiotics for a prolonged period is an important means of preventing infection and encouraging the regrowth of skin on severely burned areas of the body. Physicians recommend that extensively burned patients be given two or three daily intramuscular injections of penicillin and streptomycin, available as a single drug called Combiotic, for about three weeks. After this, oral doses of the broad-range antibiotic terramycin can take over the guard against infection.

A group of British physicians has also found antibiotics valuable in the same application. They report that the broad-range earth-mold drugs, such as terramycin, in 11 out of 12 cases effectively eradicated *Streptococcus pyogenes*, a burn-infecting organism believed to impede the establishment of skin grafts. They stress the advantage of the speed with which the antibiotics work, since skin grafts should be made as soon as possible to be most effective.

From Italy comes a report confirming the effectiveness of terramycin in a wide range of infectious diseases. Two Turin physicians found that it exerted a "brilliant therapeutic effect" against pulmonary infections, brucellosis, amebic dysentery, infection of the membranes lining the heart, and gastrointestinal infections, in a series of 19 patients. —*Medical & Pharmaceutical Information Bureau.*

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments—*Teresa Flynn* (Health visitor's certificate and Queen's Institute for District Nursing cert.) to Etobicoke Township Board of Health; *Barbara Harvey* and *Margaret Spear* (Health visitor's cert. and Queen's Institute for District Nursing cert.) to Lambton health unit; *Marian Hatcher* (Royal Victoria Hospital, Montreal, and University of Toronto general course) to Galt board of health; *Arlie (Wright) Laxton* (B.Sc.N., University of Western Ontario), formerly with Sudbury board of health, as public health nurse, Lion's Club Tuberculosis Committee, Sault Ste. Marie; *Elizabeth (Burnham) Lowe* (Saint John Gen. Hosp., N.B., and McGill University public health nursing course) to Kingston board of health; *Reta Sutcliffe* (Hosp. for Sick Children, Toronto, and McGill U. p.h.n. course) to Scarborough Township board of health.

Resignations—*Ina Dickie* as supervisor with Ottawa board of health to go to WHO in Thailand; *Jennette Gillespie* as public health nursing supervisor, Halton County health unit; *Mary Murdoch* from Oshawa board of health; *Mrs. J. (Cummings) Nelson* from Etobicoke Township board of health.

Victorian Order of Nurse

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Edmonton: *Wilma Pickering* (Royal Alexandra Hosp., Edmonton). Halifax: *Jacqueline Beaumont* (Toronto Gen. Hosp.). Hamilton: *Margaret Peart* (McMaster

University School of Nursing, Hamilton). Lincoln County, Ont.: *Agnes Dick* (B.Sc.N., McMaster U. S. of N.). Lindsay, Ont.: *Margaret Jardine* (B.Sc.N., McMaster U. S. of N.) as nurse in charge. Niagara Falls: *Jean Robertson* (B.Sc.N., McMaster U. S. of N.).

Transfers—*Barbara Bloomfield* from St. Thomas, Ont., to London, Ont.; *Betty Minke* from Hamilton to Waterloo, Ont., as nurse in charge; *Helen Nelles* from Lindsay to Hamilton.

Resignations—Calgary: *Vivian Harding* and *Helen Turnbull*. Gananoque, Ont.: *Kathryn Elson* as nurse in charge. Lunenburg, N.S.: *Mrs. F. Frittenburg* as nurse in charge. Toronto: *Eleanor Vance*. Waterloo: *Joyce Curran* as nurse in charge.

Treatment of Gout

A new synthetic drug, called Benemid Probenecid, for the treatment of gout, has been developed by and is being made available to physicians in tablet form by Sharp & Dohme, Inc. The new synthetic drug, a benzoic acid derivative, sparingly soluble in water, is said to be extremely stable by the makers and has the advantage over previously prescribed treatments of low toxicity on protracted administration. Drugs previously used in the treatment of gout were so toxic a patient could not tolerate doses large enough to be beneficial. Although a complete cure for gout is still to be discovered, the almost tasteless benzoic acid drug, which has passed rigid clinical tests, affords gout sufferers substantial relief by removing uric acid from the blood stream. Aside from creating a favorable balance between the production and excretion of uric acid, the drug is said to reduce the number of gouty attacks to a minimum.
—*Canadian Pharmaceutical Journal.*

News Notes

ALBERTA

CALGARY

Helen (Whidden) Schoening, a graduate of the 1943 class of Holy Cross Hospital, is now residing at Halkittster 34, Hanover, Germany,

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Supt. of Nurses in respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver 9, B.C.

with her two small sons. Her husband is serving with the 27th Brigade.

BRITISH COLUMBIA

CHILLIWACK

The annual tea, sponsored by Chilliwack Chapter, was planned for June at a meeting of the group. N. Kennedy gave a report on the bursary to be offered to a student of the local high school intending to train as a nurse. Miss Munro visited the school, explaining the plan to those interested. Resolutions from the Local Council of Women were discussed. A later meeting was to take the form of a dinner party, Mmes P. Penner and G. Gordon in charge of tickets.

VANCOUVER

St. Paul's Hospital

The School of Nursing graduated the largest number of students this year ever to receive their diplomas—138, including laboratory technicians. Something new was added to the festivities—a Mother and Daughter Tea. E. Rossiter was the guest speaker at a recent alumnae meeting. The matron of Shaughnessy Military Hospital told the members of her work with the R.C.A.M.C. during the war and about her present duties with the D.V.A. The nurses' bowling ended up with a banquet when about 35 members were present. Fourth South won the cup this year, with A. Owens as captain. Mrs. A. Barnes had the high aggregate score while the high single score was held by J. Blaney. The cups donated by the Drs. Frost are something to be proud of. The girls really went all out this year—even to having sweaters. Every year sees more enthusiasm.

Sr. M. Dennis has been transferred from Dawson Creek to Vanderhoof. S. McNeely is on the staff at Abbotsford Hospital. M. McLeod is on duty at Chilliwack Hospital. Sr. Helen Marie has been transferred to New Westminster. A. Berg plans to work in Montreal. J. Lehman is at the Children's Hospital. P. Baseley was on a visit from Seattle. A. (Suckling) Clemons is living at Santa Ana, Calif. H. (Lutes) Engbaum is enjoying her work at Merced Hospital, Calif., where she is in charge of the ward for old people. Srs. Damian and Anne of the Sacred Heart are attending college in Seattle.

MANITOBA

WINNIPEG

General Hospital

Uniforms—past and present—were the topic of the panel given by Jean Whiteford following a regular business meeting of the alumnae association. The original W.G.H. uniform, the changes made in it up to the present day, the newer trends in uniforms, and those worn in schools of nursing in other Canadian hospitals, were modelled. Slides of several uniforms in American hospitals were also shown. The graduates of the class of 1952 were guests.

At the annual alumnae meeting reports were read by the committee conveners. It was voted that $75 be given to the Zenana Bible and Medical Mission Society to aid in the training of a native nurse. The following officers will serve during the coming months:

Honorary president, E. Gilroy; president, Mrs. J. E. Wilson; vice-presidents, Mmes D. R. Williams, G. H. Palmer, W. Stevenson; recording and corresponding secretaries, Mrs. G. Kent and A. Robertson; treasurer, Mrs. R. J. Sturgeon. Other executive members include: I. Johnson, C. Cosgrove, A. Billinkoff, J. Kerr, I. Aikman, S. Tretiak, Mmes W. H. Anderson, J. F. Duff, C. G. Kershaw, A. E. Reynolds, J. D. McQueen, E. Grist, R. E. Emmett.

Courses in Civil Defence have been taken by the graduate staff and student nurses at the hospital, with J. DeBrincat as organizer.

Dr. B. Best was guest speaker at the graduation exercises of the School of Nursing. The valedictorian was D. Broughton. Scholarships were won by: J. Hagglund, C. S. Riley, W. A. Murphy, H. Sigurdson, and H. E. Sellers. The following were recipients of alumnae awards: B. Caughlin, I. Nicholls, E. Leverton. *The Canadian Nurse* Award was won by E. Green.

G. Callin is returning as surgical clinical instructor, succeeding J. Hood who will reside on the west coast.

Misericordia General Hospital

Twenty-eight nurses graduated at the recent exercises when the guest speaker was Judge J. Morkin and B. Hohn delivered the valedictory address. Honorary medals were presented to: J. Grose, J. Duczeminski, M. Biggar, H. Morrell, and V. Van Walleghem.

Mrs. B. A. Christeanson was in charge of arrangements for the annual graduation dance sponsored by the alumnae association. M. Lang, president, received the guests with Mrs. S. G. Hutton and Miss Boyne.

B. Ball and J. Laurendeau have left the staff for a trip to England.

NEW BRUNSWICK

FREDERICTON

Victoria Public Hospital

Mrs. J. Stone is the new president of the alumnae association, succeeding A. Miller. Election of officers and naming of committees took place during the annual reunion dinner when upwards of 120 graduates attended. Special guests included M. E. Ingham, director of nurses at the hospital, Dr. H. H. MacKinnon, guest speaker, and members of the 1952 graduating class.

The following participated in the various toasts: V. Good, M. Lee, L. Currie, Mmes H. Morton, D. Atcheson, P. Jewett. Miss Ingham reviewed the origin and history of the alumnae, stressing the necessity of unity and cooperation and the importance of allowing the younger, fresher minds of the recent graduates to take responsible positions in the

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alumnae. Miss Ingham mentioned recent changes in the hospital with regard to the student nurses, the furnishing of the new Queen St. residence, and the redecoration of the senior residence now in process of renovation. She also thanked the alumnae for their annual prize, donated to a member of the graduating class.

Dr. MacKinnon spoke of the important part the power of suggestion can play in human behavior, treating the subject from all angles.

Mrs. A. M. Grant was convener for this event, assisted by Mmes J. D. Pugh and R. Sherwood.

Assisting Mrs. Stone on the executive are the following: Honorary president, Miss Ingham; vice-presidents, Mmes F. Wilson, G. McGinnis, Miss G. Bruce; secretary-treasurer, Mrs. M. J. Smith, assisted by K. MacFarlane; publicity, Mrs. M. Scott; additional executive, M. Barry, Mrs. B. Colter.

Twenty-three nurses received their diplomas and pins at the graduation exercises of the School of Nursing. The valedictorian was J. Chandler. Prize winners included: K. M. Hull, M. Armstrong, I. A. Turnbull, M. J. Langley, O. Underhill, Mrs. M. Duncan. Prizes in the intermediate year were won by N. Goulding and E. Haines. N. Boyd was vocal soloist during the program, accompanied by H. Shorten.

Mr. J. K. Chapman, of the University of New Brunswick history department, delivered the address to the new graduates. He gave a strong warning to hold fast to the principles of liberalism in our society or suffer the loss of democracy and the terror of a third world war.

Moncton

At a meeting of Moncton Chapter, presided over by L. Russell, discussion centred on superannuation for nurses. The Tuberculosis Hospital was the locale of a later meeting when a report on the Registry Board was heard prior to the routine chapter business. It was decided to hold a Cooking Sale. It was learned that the nurses had attended St. John's United Church and St. Bernard's Church in uniform in connection with the Nurses' Memorial Services held in May. E. Warman, public health nurse, gave a short talk on "Personality Problems," followed by a film on mental hygiene. Refreshments were served by the nurses of the Tuberculosis Hospital.

Nurses' Hospital Aid

Mrs. J. Morrell, the president, was in the chair at a recent meeting of the Aid. Mrs. Pettet reported on the very successful Leap Year Tea. Arrangements were made for a Tag Day and for a dinner and dance in honor of the Moncton Hospital graduation class. For the latter event Mrs. S. Sinclair was named convener assisted by Mmes H. Henderson, G. Shaw, K. Carroll, M. Perry, N. Smith, H. Robinson, G. Whelan, J. Innes, and J. Morrell. Mmes R. Atherton and G. Cooper, who had the misfortune to lose exten-

sively in a fire which destroyed their apartments, were suitably remembered with gifts. Mmes C. E. Doyle and A. Sowerby were welcomed as new members. New equipment is to be presented to the classroom of the hospital. Refreshments were served by Mmes J. Atkins, F. McConnell, and A. DeBow.

SAINT JOHN

F. Saunders, president, was in the chair at a meeting of Saint John Chapter when the student nurses of the General Hospital were made welcome. The president represented the chapter at the C.N.A. biennial convention in Quebec City. May 4 was the date for the Nurses' Annual Memorial Service. M. Murdoch was named convener of the arrangements committee for the N.B.A.R.N. annual meeting to be held in Saint John in September. At the conclusion of the business session, an interesting film was shown on "Quebec and the Gaspé Coast." A talk on the Nursing Aspects of A.B.C. Warfare was given by Vicki LaRose, director of nursing services and nursing stations for the New Brunswick Division of the Red Cross.

Thirteen members were present at the April meeting of the Public Health Nursing Section of the local chapter when Miss Henderson, president, welcomed Miss Wilson, a member of the V.O.N. staff, to the group. Miss Walker volunteered to send the food parcel. Leona Selly, of the Canadian Bank of Commerce, as guest speaker described her trip to Europe last fall.

The chapter's Private Duty Section staged their annual Easter Ball when the guests were welcomed by Miss Saunders, J. Crozier, section convener, and E. Menzies, one of the joint conveners of the dance committee. His Worship the Mayor and Mrs. G. E. Howard were among the patrons for this event. Miss Crozier was assisted in arrangements by E. Fisher, C. Howard, and Miss Menzies.

General Hospital

Plans for the annual dinner, dance, and bridge were made at a meeting of the alumnae association when B. Selfridge was named convener for entertainment of the graduates. A. Ross, the president, was in the chair and the senior students were special guests. The association was, at the same time, hostess for a theatre party for the intermediate students who joined the gathering for refreshments. A rummage sale is scheduled for the future, with Mrs. R. Corbett as convener. It was decided to entertain the delegates attending the N.B.A.R.N. annual meeting in September at a tea and conducted tour of the hospital. The members brought a shower of food to be shipped overseas. A Bring and Buy Sale was held and made a substantial difference in funds on hand. Enid Barker, occupational therapist for the D.V.A., showed a descriptive film of types of occupational therapy and the results obtained. Mrs. M. O'Neill was in charge of refreshments.

M. McKinney and H. Ryder have resigned from the general duty staff to join the R.C.A.M.C.

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• Course begins ***September 8, 1952, January 12, 1953,*** and ***May 4, 1953.*** Enrolment limited to a maximum of six students.

For further information write to:

Supt. of Nurses, General Hospital, Winnipeg, Man.

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• Course begins ***Aug. 25, 1952, Jan. 12, 1953,*** and ***May 4, 1953.*** Enrolment limited to a maximum of eight students.

For further information write to:

Supt. of Nurses, General Hospital, Winnipeg, Man.

ST. STEPHEN

A. Branscombe of Beaver-Lodge, Alta., who was a former superintendent of the Chipman Memorial Hospital and the first president of the N.B.A.R.N., was a welcome guest at a meeting of St. Stephen Chapter. The N.B.A.R.N. president—M. Hunter—was the guest speaker at a later meeting which was preceded by a banquet attended by 49 members and eight graduates of the class of 1952 who attended as guests. Mrs. H. Irving's home was the scene of the May meeting when 21 members were present. The guest speaker was Mrs. G. McGarrity who gave a humorous talk on "Hobbies for Nurses." Many of the nurses brought samples of their hobbies for display.

NOVA SCOTIA

NEW GLASGOW

Aberdeen Hospital

E. G. McCabe, a member of the class of 1945, was one of the heroines of the crash of a U.S. hospital plane in Tokyo, Japan. She was one of three flight nurses on the craft with 59 patients, all of whom, along with the crew, were saved from serious injury. Miss McCabe, now a Pilot Officer, was on the staff at Camp Hill Hospital, Halifax, for some time prior to enlisting in the R.C.A.F. about a year ago.

The four-engine military evacuation plane crashed during take-off but quick action by the pilot, crash crews, and three flight nurses saved the passengers from death or serious injury. Twenty-seven of the patients were litter cases. Within three hours all patients, except two slightly hurt in the crash, were en route to Hawaii aboard another plane.

ONTARIO

DISTRICT 1

CHATHAM

The Public General Hospital Alumnae Association entertained the 1952 graduation class at a Pot-Luck Supper and social evening when each nurse was presented with a white bible. Mrs. R. Judd, president, reported that over $1,000 had been raised as the alumnae's contribution to the Building Fund for the addition of a new wing to the hospital. M. Houston was named as representative to the district meeting in Leamington. Of coming interest to the members will be films on Wedgewood and Royal Doulton.

Many graduates living in the Blenheim area are interested in starting an alumnae chapter.

DISTRICT 5

OSHAWA

The members of the district were guests of Chapter 1 at a meeting held at the General Hospital. With Miss Hendrikz, the chairman, presiding some very interesting reports were presented, including one on the activities of the Civil Defence Committee. It was reported that fifteen 12-hour courses on A.B.C. Warfare have been given in the district to date. These courses will be continued in the fall

until all nurses have attended. It was urged that volunteers take the special instructors' course which will enable them to carry on this important teaching.

A new Committee on Education has been formed, with members representing most of the nursing schools and teaching agencies in the district. It has plans for a busy year ahead with one of its first projects being a study of methods in teaching nutrition and diet therapy.

In the evening the members enjoyed a turkey dinner when Mr. A. Wedgery, Reg. N., entertained the group with well known songs. The guest speaker, Mr. F. J. Grindley, president of Britman Ltd., Oshawa, chose as his topic "International Trade." He inspired the members to look seriously at the events going on in the world and to consider their cause.

District 6

Belleville

The semi-annual dinner meeting of District 6 was held here when a symposium on diabetes was given by Dr. B. Cronk, L. Sine, clinical instructor at the General Hospital, and J. Green, student nurse at B.G.H. During the business meeting a letter was read from E. J. Merry, superintendent of the Queen's Institute of Nurses, England, acknowledging a gift of linen sent by the district. It was decided to pay the transportation expenses of 16 students to the annual and semi-annual meetings of the district. Miss McGeary, district chairman, was elected as delegate to the C.N.A. convention in Quebec City. The members of Chapter A were conveners for this meeting.

District 7

Brockville

Since the annual meeting of the General Hospital Alumnae Association in January, the annual Pot Luck Supper was enjoyed by the members. A cooking school was held in May in conjunction with Canada Packers Ltd. and proved a successful venture. The alumnae entertained the graduates of the 1952 class at a dinner held at Hotel Manitonna.

Kingston

Ontario Hospital

The following officers are serving for the alumnae association during the coming months: Honorary president, Mrs. D. O'G. Lynch; president, Mrs. N. R. Ferguson; vice-presidents, E. Lyon, Mrs. F. Brim; secretary, Mrs. E. Ruddell; treasurer, Mrs. L. Orr. Additional executive members include: Misses Smith, F. Latimer, E. Rutherford, Mmes A. Kennedy, M. Pillar, A. E. Peters, G. Pomeroy, R. Roach, W. Newman, G. Greenwood, K. White, E. Scrutton.

In April a bridge and euchre was held when the guests were received by Miss Smith, Mmes Ferguson, Pomeroy, and Brim. Thanks are extended to Dr. Lynch and everyone else on the staff who assisted. Twenty-five dollars

NURSING-ARTS GUIDE

By Ruth Rhodes Joseph, Brackenridge Hospital School of Nursing, Austin, Texas. An integrated course, arranged in the unit system. In constant use for eight years and revised annually, the material has proved successful in widely divergent types of schools. 94 pages, spiral binding, 1951. $2.50.

ORTHOPAEDIC NURSING

By Frederick J. Knocke and Lazelle S. Knocke. A new text that is far ahead of the field. A distinguished group of authorities here give a clear-cut presentation of modern orthopaedics and modern orthopaedic nursing. 704 pages, 212 illustrations, 1951. $6.25.

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For further information apply to:

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• Announces a five-month supplementary *Clinical Course* (approved by the New York State Education Department) *for Graduate Registered Nurses* in the nursing care and treatment of diseases of the eye, ear, nose and throat. Operating room training is included in the course.

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of the proceeds of a raffle were donated to the children's wing of the Kingston General Hospital. The proceeds of the bridge—$60—will be used for educational purposes among the students of O.H.

In May a dinner was given in honor of the class of 1952 when the guest speaker was Mrs. Marion Earl whose topic was "The Graduate Nurse as a Citizen." At the graduation exercises, Rev. Fr. Sullivan addressed the nurses.

E. Moulton, who was awarded a Kellogg Foundation Fellowship, is continuing her studies at Columbia University. She has been on the staff of Queen's University School of Nursing, lecturing in nursing education. N. Brown is with the V.O.N. in Sudbury. F. Hanna is on the staff of the McGregor Clinic, Hamilton. M. Hollingsworth, M. Johnston, and M. (Wityk) Doliszney are on the staff of the O.H. in Kingston. M. Bernasconi has returned to the teaching staff after a year at the University of Toronto School of Nursing. I. Cowen is at the Peterborough Civic Hospital.

District 8

Ottawa

Lady Stanley Institute

Sixty-four members were present at the annual meeting and dinner of the alumnae association when the guests of honor were E. McColl, former superintendent of Ottawa Maternity Hospital, and G. Garvin, former superintendent of Strathcona Hospital, Ottawa.

The following officers were elected for the coming months: Honorary president, Mrs. W. S. Lyman; honorary vice-presidents, M. Stewart, E. Young; president, Mrs. J. A. Steele; vice-president, Mrs. G. O. Skuce; secretary, Mrs. P. Bryce; treasurer, M. Scott. Board of directors, C. Pridmore, Mmes W. E. Caven, M. E. Jones, L. G. Gisborne. Additional executive members include: D. Booth, E. Johnston, Mmes C. Port, G. C. Bennett, J. Waddell. M. Scott was elected to the Community Registry Board of Directors.

St. Luke's Nurses Alumnae

A very successful bridge was held under the auspices of St. Luke's Nurses Alumnae Association when Controller John Powers drew for prizes. The proceeds were for charitable purposes.

Quebec

Montreal

General Hospital

The following graduates who attended the McGill School for Graduates Nurses have completed their courses as follows: H. Knox—public health degree. Teaching and supervision certificate—C. McMillan, M. Lewis, A. Prescott. Public health nursing certificate—A. Cleland, C. Moore, M. Seifert, M. Kerr, J. Woodruff.

A tea was held in honor of Mrs. P. Read who has resigned her position at the Western Division.

Royal Victoria Hospital

The alumnae association entertained the members of the graduating class at dinner at the Ritz Carlton Hotel when Dr. C. P. Martin of the Department of Anatomy, McGill University, was the guest speaker. The toast to the guests was proposed by Mrs. E. Daley, responded to by M. Maxwell.

One hundred graduates received their

diplomas and pins at the exercises when they were addressed by Dr. C. B. Pierce, radiologist-in-chief.

E. Hartig returned in September from India to complete her B.Sc.N. at the University of Western Ontario. Since 1946 she has been assistant superintendent of nurses at the Lutheran Hospital, Rajahmundy, South India. She will return after Christmas under the auspices of the Mission Board of the Lutheran Church to carry on her work as a missionary nurse. There is a great need for English textbooks in the training schools in India and if any readers have discarded ones they would be a great help at the *School of Nursing, Christian Medical College, Vellore, South India*. C. Robertson has left for England to join the staff of the National Hospital in London.

Quebec City

Jeffery Hale's Hospital

Eighteen members were present at a meeting of the alumnae association when Mrs. L. Teakle, the president, was in the chair.

M. Whealan and Y. Roy have resigned from the staff to be married. They were entertained at a tea prior to their departure. J. Gaudet has joined the O.R.

SASKATCHEWAN

Saskatoon

At the annual meeting of Saskatoon Chapter the following officers were elected for the coming months: President, A. Hazen; vice-presidents, N. Humphreys, A. Chudy; secretary, E. Fedoruk; treasurer, Mrs. M. Phillips. Councillors, Mrs. H. A. Armstrong, Sr. Ste. Croix, M. L. Luton, L. Reynolds, E. Waddington, M. Jarvis. Committee conveners: Program, M. Cooke; visiting and flowers, D. Haugan; registry, L. Reynolds; ways and means, D. Weidenhammer. The press representative is J. Byam.

Miss Hazen, as the new president, entertained the executive members at the School for the Deaf when her guests were conducted on a tour of the school.

St. Paul's Hospital

Fifty-nine nurses graduated from the School of Nursing this year when celebrations began on May Day with a banquet and dance given by the second-year student nurses for their "big sisters" in a distinctly nautical atmosphere. The Bessborough Hotel was the scene of a dance given by the alumni for the new graduates. The freshman class sponsored a tea as a tribute to the graduates' mothers. Graduation mass and presentation of St. Paul's pins by Rev. D. J. Mulcahey, followed by breakfast, was another highlight, culminating in the graduation exercises.

The annual convention of the Saskatchewan Council of Catholic Nurses took place at St. Paul's in May. Two students—B. Baldwin (3-A) and R. Bienvenue (3-B)—represented the school at the C.N.A. convention in Quebec City.

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La Société Canadienne de la Croix-Rouge,
95 rue Wellesley, Toronto 5, Ontario, Canada.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Director of Nursing by Aug. 26 for 150-bed General Hospital. Staff of 35 registered nurses, 5 trained nursing assistants, 75 students enrolled in 3-yr. course. Salary commensurate with qualifications & experience. Apply Administrator, General Hospital, Chatham, Ont.

Public Health Nurses for Dept. of Health, City of Ottawa. Generalized public health nursing. Superannuation. 3 wks. vacation annually. Apply Miss Pearl Stiver, Director, Public Health Nursing, Dept. of Health, City of Ottawa, 48 Rideau St.

Ward Supervisor, General Duty Nurses, Children's Nursery Nurse, Operating Room Nurse for immediate employment at Saguenay General Hospital, Arvida, Que. Regular employment. Room, board & laundry service of uniforms provided. Very favorable living & working conditions. Starting salaries commensurate with qualifications & experience. Apply by letter, giving full particulars, Aluminum Co. of Canada Ltd., c/o Mr. A. C. Meyer, 1700 Sun Life Bldg., Montreal 2, Que.

Asst. Dietitian immediately. Gross salary: $230. For particulars apply Medical Supt., Fort William Sanatorium, Fort William, Ont.

Graduate Nurses immediately for Central Alberta Sanatorium, Calgary, Alta. Minimum gross monthly earnings—$200 & up—depending on experience, less $30 for maintenance. Excellent holiday, sick leave & pension benefits. Apply Supt. of Nurses.

Staff Nurses for General Hospital. 40-hr., 5-day wk. Salary: $250 with laundry of uniforms. $10 extra for evening, night, maternity & operating room duty. Increases yearly. Temporary permits & housing available. Apply Director of Nurses, Mercy Hospital, Sacramento 16, California.

General Staff Nurses for newly constructed hospital. Starting salary: $175 per mo. plus $10 differential for afternoon duty. Additional pay for post-graduate study & operating room technique & obstetrics. Good personnel policies. Apply Director of Nurses, General Hospital, Guelph, Ont.

Applications will be received by the undersigned up until 12 o'clock noon the 21st day of July for the position of **Supervising Nurse** for the Kent County Board of Health Unit. Applicants to have qualifications as laid down by Dept. of Public Health, Ont. Applications will also be received for a **Staff Nurse,** qualifications as laid down by Dept. of Public Health, Ont. W. M. Abraham, Sec.-Treas., Kent County Board of Health, Kent County Municipal Bldg., 7th St., Chatham, Ont.

General Duty Nurses for Operating Room. Salary: $2,340 per yr. Apply Director of Nursing, Civic Hospital, Peterborough, Ont.

Public Health Nurses (2) for Local Board of Health, 2090 Wyandotte St. E., Windsor, Ont. Salary range: $2,740-3,220 with starting salary based on experience. Positions carrry pension, Blue Cross, medical & surgical care, sick leave & other privileges.

THE BRITISH COLUMBIA CIVIL SERVICE

requires—Nursing Supervisors for the
Provincial Mental Hospital, Essondale, B.C.

Salary: $238 rising to $288 per month, including Cost of Living Bonus. Qualifications: Eligible for registration in B.C. with certificate in teaching and supervision and post-graduate study (or its equivalent) and experience in psychiatric nursing; must be capable of administering and supervising a group of ward units.

Candidates must be British subjects, under the age of 40, except in the case of ex-service women who are given preference.

Further information and application forms may be obtained from:
Director of Nursing, Provincial Mental Hospital, Essondale, B.C.
or the **B.C. Civil Service Commission, Weiler Bldg., Victoria, B.C.**

Nursing Arts Instructor & Asst. Supervisor for Operating Room for 450-bed General Hospital with 150 students Apply Director of Nursing, General Hospital, Saint John, N.B.

General Duty Nurses. Salary: $162.50 per mo. for new graduates plus 2 meals, laundry. 8-hr. day, straight shift. $15 differential. evenings; $10 nights. Vacation, sick time, statutory holidays, annual increments. Financial recognition for university, post-graduate work or yrs. of experience. Also **Operating Room Supervisor** for Oct. 1. Mature person with wide experience. Salary open. Annual increments, vacation & sick time. 48-hr. wk. Will pay travel expenses for personal interview. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Public Health Nurses for generalized program. Minimum salary: $2,400 with allowance for previous experience & annual increments of $120. Cumulative sick leave plan. Pension plan & Blue Cross Plan available. Interest free loans available for purchasing car if necessary. Liberal transportation allowance & holidays. Apply Dr. A. E. Thoms, Director, Leeds & Grenville Health Unit, Victoria Bldg., Brockville, Ont.

Nursing Arts Instructor. Nurse experienced in bedside nursing & ward administration with post-graduate course in Teaching & Supervision. Salary commensurate with experience. Starting minimum: $225. **Clinical Instructors**—Surgical, Obstetrical, Pediatrics. Nurses experienced in bedside nursing with p.g. course in Clinical Supervision. Apply Miss S. Davidson, Director of Nurses, McKellar General Hospital, Fort William, Ont.

Instructor of Nurses for Training School of 35 students. Attractive salary & maintenance provided. Usual holidays & sick time allowed. Apply Medical Supt., Victoria Hospital, Winnipeg, Man.

Asst. Night Supervisors (2) capable of taking charge in Delivery Room. 44-hr. wk. Gross salary: $210-265. May live in residence. For full particulars apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

Night Supervisor, General Duty Nurses, Registered & Grace Maternity Graduates, Laboratory Technician. Apply, stating experience, Supt., Queens General Hospital, Liverpool, N.S.

Dietitian (experienced) & **Registered Nurses for General Duty** for Royal Inland Hospital, Kamloops, B.C. 200 beds. 45 students. Apply Director of Nursing.

Dietitian & Graduate Nurses for General Duty. Apply, stating qualifications, Supt., The Cottage Hospital, Pembroke, Ont.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Operating Room Nurse (salary open) & **Registered Nurses** for 60-bed General Hospital. Salary: $150 per mo. plus full maintenance. 44-hr. wk. 3 wks. vacation. Apply Supt., Public Hospital, Smiths Falls, Ont.

Registered Nurses (2). Salary: $13 per 8-hr. day plus one meal. Apply Supt., W. J. Harrington, Harworth Hospital, 531 E. Grand Blvd., Detroit 7, Mich. (*Phone WAlnut 3-7319*)

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A career specialty for the Graduate Nurse. ***Eligibility:*** Graduates of Accredited Schools of Nursing. ***Course:*** Study of the basic sciences related to Anesthesia. Clinical training in all phases of General Anesthesia, Resuscitation, and Inhalation Therapy. ***Professional Opportunities:*** Full-time position in teaching and non-teaching hospitals in United States. For special course write: **Mary H. Snively, R.N., In Charge of Nurses' Training Programs, Duke Hospital, Durham, North Carolina.**

Public Health Nurses (qualified) for Peel County Health Unit near Toronto. Generalized program. Salary schedule: $2,400-3,000 per yr. Liberal car allowance. For full information apply Dr. D. G. H. MacDonald, Director, Peel County Health Unit, Court House, Brampton, Ont.

Public Health Nurses for Greater Montreal Branch of Victorian Order of Nurses. Interesting program of nursing care & health education to families & patient study groups. Stimulating staff education program. Salary: $2,400-3,000 with annual increments. Initial salary based on previous experience. 5-day wk. 4 wks. vacation. Apply District Supt., Victorian Order of Nurses, 1246 Bishop St., Montreal 25, Que.

Public Health Nurses (qualified) by Dept. of Public Health, City of Toronto, for generalized public health nursing service. Salary: $2,974 with yearly increases to $3,391 per annum. 5-day wk. Sick leave & Pension Plan benefits. Apply Dept. of Personnel, Rm. 320, City Hall, Toronto, Ont.

Public Health Nurses for Simcoe County Health Unit for generalized program. Salary: $2,300-2,800. Annual increment $100. Sick leave plan. 4 wks. vacation. Blue Cross Plan available. Transportation allowance. Apply Mr. J. R. Coleman, Sec.-Treas., Court House, Barrie, Ont.

Vancouver General Hospital invites immediate inquiries from **Graduate Nurses** for Staff Vacancies. Salaries: $222 as minimum & $258 as maximum per mo. plus shift differentials for evening & night duty. Employee benefits include: 44-hr. wk; 11 public holidays; 4 wks. vacation; 1½ days per mo. cumulative sick leave; pension plan if under 35. Acceptable qualifications for registration in B.C. necessary. Apply Director of Nursing, General Hospital, Vancouver 9, B.C.

Staff Nurses for Crippled & Convalescent Children's Hospital. Good salary. Opportunity for promotion. May live at hospital if desired. 40-hr. wk. Write for illustrated booklet Rainbow Hospital, Cleveland 21, Ohio.

Administrator (experienced) as Asst. in School of Nursing Office. Initial gross salary: $103 bi-weekly plus Cost of Living Bonus of approx. $6.00 per wk. **Instructor in Dietetics for Nurses**—classroom, dietetic laboratories, wards. Initial gross salary: $93 bi-weekly plus Cost of Living Bonus of approx. $6.00 per wk. For other perquisites—vacation, illness, pension, etc.—& further information apply Supt. of Nurses, General Hospital, Hamilton, Ont.

Graduate Floor Duty Nurses for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus Cost of Living Bonus. For other perquisites & further information apply Supt.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $83 plus Cost of Living Bonus of approx. $6.00 per wk. 44-hr. wk. For other perquisites & further information apply C. E. Brewster, Supt. of Nurses.

Graduate Nurses. Salary: $225 per mo. 40-hr. wk. Apply Warren Hospital, Warren, Minnesota.

Registered Nurses & Licensed Practical Nurses for hospitals & fully modern outpost nursing stations. Beginning salaries—Registered Nurses: $2,300-2,720. Licensed Practical Nurses with 2 yrs. experience: $1,740-2,040. 44-hr. wk. 3 wks. leave with pay annually. Apply Indian Health Services, 522 Dominion Public Bldg., Winnipeg, Man. *Phone 927-100.*

Graduate Nurses for completely modern West Coast hospital. Salary: $210 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $215-253. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Staff Nurses for 250-bed hospital. Salary: $2,340 per annum. 45-hr. wk. 30 days holiday after 1 yr. service. Railway fare up to $50 refunded at end of 1 yr. **Nursing Arts Instructor, Science Instructor, Clinical Instructor**—with university post-graduate certificates. Salary: $2,760 per annum. For further information apply Director of Nursing, General Hospital, Port Arthur, Ont.

Registered Nurses for General Duty Staff. Salary commences at £37-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

General Staff Nurses will find real opportunity to realize their ideals in our 337-bed Teaching Hospital with University affiliation. Community offers unlimited choice of cultural & recreational facilities. 40-hr. wk. 3 wks. vacation. Paid sick leave. Rotating shift $1.30-1.40 per hr. Differential of 10 cts. per hr. for evening & night shifts. Apply Director of Nurses, Evanston Hospital, 2650 Ridge Ave., Evanston, Illinois.

General Duty Nurses urgently needed for R.W. Large Memorial Hospital of United Church of Canada at Bella Bella, 300 miles north of Vancouver on the B.C. coast. Salary: $210 per mo. less $40 for board, room, laundry of uniforms. 2 annual increments of $5.00 per mo. Sick time, 1½ days cumulative. 1 mo. annual holiday plus 10 days in lieu of statutory holidays. Transportation to Bella Bella refunded after 1 yr. service. Apply to Matron.

General Duty Nurses for Operating Room, Pediatrics & Surgical & Medical Nursing. For information & personnel policies apply Director of Nursing, Victoria Hospital, London, Ont.

Nurse for modern 24-bed hospital with modern nurses' home. Starting salary: $165 per mo. with full maintenance. Usual raises. Vacations with pay & sick leave, etc. Apply Matron, Union Hospital, Vanguard, Sask.

Graduate Nurses for General Duty in 200-bed hospital in Niagara Peninsula. 48-hr. wk., no broken shifts. Salary: Days, $140; evenings, $150; nights, $145 plus full maintenance in attractive residence. 21 days vacation plus 8 statutory holidays. Train fare refunded on completion of 1 yr. service. Increments for 1st 3 yrs. Sick leave cumulative to 18 days—paid if not used. Apply Director of Nursing, County General Hospital, Welland, Ont.

Graduate Nurses for General Duty on Medical, Surgical & Obstetrical floors in 113-bed hospital, located near Chicago. Starting salary: $255 with afternoon bonus $30 & night bonus $20. Apply Personnel Director, Highland Park Hospital, Highland Park, Illinois.

Graduate Nurses for 175-bed Tuberculosis Sanatorium near Prince Rupert. Salary for General Duty, $232 per mo. plus yearly increases. Room, board, laundry at $30 per mo. Transportation refunded on promise of 1 yr. service. Apply airmail, giving full details of experience, Matron, Miller Bay Indian Hospital, Box 1248, Prince Rupert, B.C.

Registered Nurses for General Duty in 90-bed General Hospital in city of 10,000 located 50 miles from St. Paul. Excellent streamliner rail service to St. Paul & Chicago. Beginning salary: $225 plus semi-annual increases of $5.00 for 2 yrs. Additional $10 for night duty & $15 for 3:00-11:00 p.m. shift. 40-hr. wk. 3 wks. vacation with pay after 1 yr. Paid holidays, sick leave & other benefits. Apply Director of Nurses, St. John's Hospital, Red Wing, Minnesota.

Registered Nurses (2) & Matron for hospital with 27 set up beds. Salaries: $160 & $200 per mo. plus full maintenance. 1 mo. holiday & usual sick leave. Hospital located in thriving town with good train & bus service. Apply Sec.-Mgr., Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

Registered Nurses—General Duty (2): $250 per mo. Surgical (1): $275. 30-bed hospital. City of 12,000 pop. Warm central valley in Calif. Mostly surgical & medical. Apply Mrs. D. Marshall, R.N., Hanford Sanitarium, Inc., Hanford, California.

Municipal Nurses for Province of Alberta. Rural service, emergency treatment, preventive & maternity program. Salary: $2,160-3,000 depending on qualifications & experience plus modern furnished cottage. Excellent sick leave, pension & vacation benefits. Apply Director, Nursing Division, Dept. of Public Health, Administration Bldg., Edmonton, Alta.

Registered Nurses for General Duty for small General Hospital. Salary: $140 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Also **O.R. Nurse,** preferably with post-graduate training, by July 15. Salary: $155. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for St. Joseph Hospital, Mt. Clemens, Michigan. 25 miles north of Detroit, near Selfridge Air Force Base. Optional 40- or 44-hr. wk. **Staff Nurses:** $12 day duty; $13 afternoon or night duty. State Standards. Apply Director of Nursing Service.

General Duty Nurses (2) for 65-bed hospital. Salary: $150 per mo. with 3 annual increments of $5.00. Straight 8-hr. duty. $5.00 extra for evening & night duties. Full maintenance. 4 wks. vacation at end of 1 yr. service. Apply Alexandra Marine & General Hospital, Goderich, Ont.

General Duty Nurses (2) for 36-bed hospital on C.P.R. main line & Trans-Canada highway. Salary: $155 & full maintenance with $5.00 increment every 6 mos. Sick leave with pay. 1 mo. holiday with pay plus statutory holidays each yr. 8-hr. day, 44-hr. wk. with rotating shifts. Apply Supt., Municipal Hospital, Brooks, Alta.

General Duty Nurses for 250-bed General Hospital. Good nurses' home. Starting salary: $250 per mo. 40-hr. wk. Night, O.B., T.B., & Isolation duty $10 extra. Passport necessary. Apply Director of Nurses, County General Hospital, Box 231, Merced, California.

General Duty Nurses for 32-bed hospital. Rotating shifts. 3 wks. vacation annually. 12 days sick leave. Located on Highway 31, 30 miles south of Ottawa & 18 miles north of Highway 2. Good bus connections. Apply Supt., District Memorial Hospital, Winchester, Ont.

Registered Nurses, with Pediatric experience preferred, as **Head & Asst. Head Nurses** for Pediatric-Orthopedic Hospital. Apply Director, Shriners' Hospitals for Crippled Children, Montreal 25, Que.

Asst. Director of Nursing Service by Sept. 1 for 600-bed hospital. Post-graduate study & experienced required. Salary: $2,940. 44-hr. wk. Apply Director of Nursing, Western Hospital, Toronto 2B, Ont.

Evening Nursing Supervisor (1) **& Night Nursing Supervisor** (1). Responsible positions, interesting duties, including major surgical nursing. Up-to-date equipment, comfortable living quarters, good working conditions, group insurance, retirement plan, etc. Positions open at Manitoba Sanatorium, Ninette, Man., 260-bed institution. Salary: $190-200 per mo. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Registered Nurse to assist in Oral Surgeon's office. Basic salary: $150 per mo. with annual increase. State qualifications. Apply Dr. James Passalis, 313 Medical Arts Bldg., Winnipeg, Man.

General Duty Nurses for 500-bed Teaching Hospital with well planned rotation schedule. Salary: $210 per mo. gross plus annual increments for 4 yrs. B.C. registration required. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

General Duty Nurses (2) for 50-bed Hospital for Crippled Children. Salary: $200 per mo. less $44 board & lodging. 44-hr. wk., 28 days annual vacation & 10 statutory holidays. Single room living accommodation in new residences adjacent to Solarium which is situated by the sea within driving distance of Victoria, B.C. Recreational facilities include tennis, swimming & boating. Apply, stating age & qualifications, Director of Nursing, Queen Alexandra Solarium for Crippled Children, Cobble Hill P.O., V.I., B.C.

Graduate Nurse for General Duty. Salary: $165 per mo. plus $60 bonus each 6 mos. completed service. Full maintenance in separate modern residence supplied. Apply Matron, Municipal Hospital, Islay, Alta.

Registered Nurses for General Duty for 80-bed Municipal Hospital. Salary: $160 per mo. with full maintenance & laundry provided. $5.00 per mo. bonus at end of each 6-mo. period. Fare from Edmonton refunded after 6 mos. service. 3 wks. vacation after 1 yr. & all statutory holidays. Straight 8-hr. duty. Comfortable nurses' home. Apply Nursing Supt., Municipal Hospital, Grande Prairie, Alta.

Instructor of Nursing, Clinical-Obstetrical Supervisor & Operating Room Supervisor—all applicants must be qualified—for Victoria Public Hospital, Fredericton, N.B. Apply Director of Nursing.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. **Scrub Nurse.** Salary: $183.83 less $33 for perquisites. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Supt. of Nurses, Asst. Supt. of Nurses for School of Nursing. Also **Operating Room Supervisor.** Salary: $220 per mo. gross. **Nursing Arts Instructor.** Salary: $220 gross. **Science Instructor.** Salary: $220 gross. **Night Supervisor.** Salary: $220 gross. **Asst. Night Supervisor.** Salary: $210 gross. **Head Nurse.** Salary: $215 gross. **Laboratory Technician.** Salary: $180-190 gross. **General Duty Nurses.** Salary: $180-195 gross depending on experience. 44-hr. wk. 2½ days holiday per mo. Half day on statutory holidays. 1½ days per mo. sick time cumulative to 30 days. Charge of $30 per mo. for board & room. Apply Business Manager, General Hospital, Medicine Hat, Alta.

Public Health Nurses (2) & Graduate Nurses (2) interested in public health work for Alberta East Central Health Unit No. 10. Apply Miss Doris Corcoran, Box 715, Camrose, Alta.

Educational Director for 200-bed General Hospital School of Nursing; approx. 80 students. 8-hr. day, 44-hr. wk. 1 mo. annual vacation. Apply, stating salary requested, Director of Nursing, General Hospital, Brandon, Man.

Science Instructor for 200-bed General Hospital School of Nursing; approx. 80 students. 8-hr. day, 44-hr. wk. 1 mo. annual vacation. Apply, stating salary requested, Director of Nursing, General Hospital, Brandon, Man.

Registered Nurse (experienced) to act as **Matron** in new 15-bed hospital. Salary: $225 per mo. & full maintenance. Also **General Duty Nurses (2).** Salary: $175 per mo. & full maintenance. Apply, stating date available, P. J. Rasmussen, Sec.-Mgr., Climax-Bracken Union Hospital, Climax, Sask.

Registered General Duty Nurses for 180-bed hospital. 44-hr. wk. 1 mo. vacation. Cumulative sick leave. Gross salary: $180-210. Credit for past experience. Annual increments. Apply Supt., Notre Dame Hospital, North Battleford, Sask.

Registered Nurses for floor supervision in 36-bed General Hospital. Starting salary: $235 with increase to $275. Meals while on duty. 2 wks. paid vacation ea. yr. 6 paid holidays. 40-hr. wk., rotating shifts every 2 wks. **Surgery Nurse.** Starting salary: $250. Emergency calls. Living quarters available close to hospital. Apply M. L. Sommerville, R.N., Supt., County Memorial Hospital, Gooding, Idaho.

Hospital Supt. Registered Nurse with hospital administration experience for 17-bed hospital in Western Quebec pulp mill community. Attractive salary. Living accommodation provided in nurses' residence. Apply, stating qualifications, experience, age, marital status, references, etc., c/o Box P, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Supt. of Nurses for Manitoba Sanatorium, Ninette, Man., by Sept. 1. Suitable background of tuberculosis nursing essential. Must also possess tact & ability to deal satisfactorily with patients & staff. Preference for person with good supervisory experience and/or training in nursing administration. Institution has 270 beds, up-to-date equipment & provides major surgical & bedside nursing. Student nurse affiliation. Good living & working conditions, group insurance, retirement plan, etc. Minimum starting salary: $3,000 per annum. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Educational Director (School of Nursing—approx. 200 students), **Asst. to Director of Nursing, Night Supervisor, Clinical Instructor, Urological Supervisor, General Staff Nurses for Maternity & Operating Room & General Wards.** Salary in accordance with position & qualifications. Apply Director of Nursing, City Hospital, Saskatoon, Sask.

Matron by July 31 for Stewart Memorial Health Centre, Tyne Valley, Prince Edward Island. 7 beds, 6 bassinets, 2 cribs. Staff of 6, including 3 R.N.'s. Local doctor. Staff quarters in bldg. Bldg. & equipment all new & modern. Salary: $1,750 per annum plus board & room. Apply Chairman, Board of Trustees.

Registered Nurses for Floor Duty in modern 50-bed hospital. Good working conditions. 8-hr. day, rotating shifts. Gross salary: $170 & $175 depending on experience. Increase every 6 mos. to maximum of $185. Apply Supt., District Memorial Hospital, Leamington, Ont.

Graduating Nurses for General Duty in all depts. Get the experience & self-reliance that only a small hospital can give you. 46-bed hospital. 44-hr. wk., rotating shifts. Salary: $235 per mo. & meals. 2 wks. vacation with pay after 1 yr. service. Apply Supt. of Nurses, Glacier County Memorial Hospital, Cut Bank, Montana.

Position Wanted

Laboratory & X-Ray Technician (experienced) desires position in city in Ontario. Apply Cecile Kohstall, Box 106, Foam Lake, Sask.

The Blue Cross Story Contest

At the 26th Biennial Convention of the Canadian Nurses' Association it was announced that 11 nurses had won awards in a story contest sponsored jointly by the Canadian Blue Cross Plans and the Canadian Nurses' Association. Under the rules of the contest, which closed on April 30, 1952, all registered nurses and senior nursing students were eligible. The contest consisted in writing stories telling of actual, true-to-life experiences in connection with Blue Cross hospital service.

The winners' names were announced by Quebec Blue Cross assistant director, Leo Leblanc. Two major prizes were awarded to Miss Shirley Hepple, of the Metropolitan School of Nursing, Windsor, Ontario, and to Miss Yvonne Levesque, public health nurse of Montreal. Miss Hepple's story told of how Blue Cross helped a young couple meet the expense of their first baby and Miss Levesque's story recounted the experiences of a family of nine who benefitted repeatedly from Blue Cross protection.

In addition, there were nine other prizes for best entries for each province. They were awarded to: *Alberta*—Miss Donna Stock, General Hospital, Edmonton; *British Columbia*—Mrs. D. J. Butler, Victoria; *Manitoba*—Miss M. R. Stockley, Winnipeg; *New Brunswick*—Miss Sue Hartley, Saint John; *Nova Scotia*—Miss A. G. Legge, Children's Hospital, Halifax; *Ontario*—Sister François René, St. Joseph's Hospital, Sudbury; *Prince Edward Island*—Miss M. McCarthy, Morrell; *Quebec*—Miss Joyce Lawlor, Montreal; *Saskatchewan*—Miss G. Chattergoon, Sanatorium, Saskatoon.

Factors Influencing Recruitment of Nurses

As one of its projects for the year 1951, the Nursing Education Committee of the New Zealand Registered Nurses' Association undertook a study of the factors influencing recruitment of girls to the nursing profession. A questionnaire was drawn up and circulated to schools of nursing throughout the Dominion with the request that it be given to students in the preliminary schools to fill in. The students were asked to state the factors which influenced their choice of nursing as a career. Replies were received from 40 schools of nursing and the following is a list of the factors in order of importance as shown by the students:

Influenced by trained nurses 146; by parents 144; by visits to hospitals 138; by working as aides in hospitals 98; by pamphlets on nursing 85; by books 83; by student nurses 71; by films 67; by talks and lectures 66; by relatives other than parents 65; by articles, magazines, and papers 54; by newspaper advertisements 45; by doctors 44; by any other persons (often sick friends in hospital) 41; by school teachers 38; by vocational guidance officers 32; by priests or ministers 24; and by radio programs 14.

A number of students stated that they had "always wanted to be a nurse" and were not influenced by any persons or advertising media. The above list provides useful information for purposes of recruitment.

It will be noted that the trained nurse is placed first and that visits to hospitals, or working in hospitals, rank high on the list. It will be of great interest to ward sisters and other trained nurses to know that it has been their influence that has encouraged the majority of girls to join the nursing profession. Perhaps it has been the skill and confidence shown in their work or their kindly attitude towards the patients and visitors but all nurses should realize the importance their bearing and behavior may have in the eyes of the public in encouraging or deterring recruitment.

—*The New Zealand Nursing Journal*

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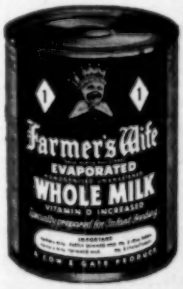

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